I I		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		STH ST	
WHITE C	OAK HEALTH CAM	PHS		CELLO, IN 47960	
				1000	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
F0000	State Licensur  Survey dates: 14, 17, 18, 19,  Facility number Provider number AIM number:  Survey Team: Regina Sande 11, 12, 13, 14, Shannon Pietr (December 11 19, 2012) Amber Bloss (In 17, 18, and 19)  Census bed ty SNF: SNF/NF: Residential: Total:  Census payor Medicare: 18 Medicaid: 15 Other: 56 Total: 89	December 11, 12, 13, and 21, 2012  er: 012355 Dec: 155782 201014410  rs, RN TC (December 17, 18, and 21, 2012) aszewski, RN, 12, 13, 14, 18, and December 11, 12, 14, 19, 2012)  rpe: 16 9 4 39 type:	F0000	Submission of this plan of correction and credible allegat does not constitute an admiss by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facilit Please accept this plan as sa and our credible allegation of compliance. White Oak Health Campus submits this plan of correction as its letter of credil allegation and requests a desl review with paper compliance considered in establishing the provider is in substantial compliance. We appreciate your consideration of this request.	y. ime ole c be
	These deficien	ncies reflect State			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 1/2012
NAME OF P	PROVIDER OR SUPPLIEF	2	STREET A	ADDRESS, CITY, STATE, ZIP	CODE	
WHITE C	OAK HEALTH CAMI	PUS	814 S 6 MONTI	CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Findings cited IAC 16.2.	in accordance with 410				
	Quality review	completed on 2012, by Janelyn Kulik,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155782	A. BUII			12/21/	2012
		100702	B. WIN			12/21/	2012
NAME OF D	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TVINIE OF T	KOVIDEK OK BOTTEIEK			814 S 6	TH ST		
WHITE O	AK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
				<u> </u>			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0156	483.10(b)(5) - (10	)), 483.10(b)(1)					
SS=C		HTS, RULES, SERVICES,					
	CHARGES	, , , , , , , , , , , , , , , , , , , ,					
		inform the resident both					
	•	ng in a language that the					
	_	inds of his or her rights and					
		lations governing resident					
	_						
		onsibilities during the stay					
		e facility must also provide					
		the notice (if any) of the					
		under §1919(e)(6) of the					
		ation must be made prior to					
	•	n and during the resident's					
		such information, and any					
	amendments to it	, must be acknowledged in					
	writing.						
	The facility must i	inform each resident who is					
	entitled to Medica	aid benefits, in writing, at					
		sion to the nursing facility					
		dent becomes eligible for					
		ems and services that are					
		ng facility services under the					
		r which the resident may					
		hose other items and					
		facility offers and for which					
		be charged, and the					
	•	es for those services; and					
		ent when changes are					
		s and services specified in					
	paragraphs (5)(I)(	(A) and (B) of this section.					
	<b>-</b>						
		inform each resident					
		ime of admission, and					
		g the resident's stay, of					
		e in the facility and of					
	charges for those	services, including any					
		ces not covered under					
	Medicare or by th	e facility's per diem rate.					
	The facility must f	furnish a written description					
	of legal rights whi						
	. 5:						

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED	
		155782	B. WIN			12/21/2012	
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	2					
WALLITE O		21.0		814 S 6			
WHITE O	AK HEALTH CAME	908		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLET	ION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	A description of the	ne manner of protecting					
		nder paragraph (c) of this					
	section;	1 3 1 ( )					
	,						
	A description of the	ne requirements and					
	procedures for es	stablishing eligibility for					
	Medicaid, includir	ng the right to request an					
	assessment unde	er section 1924(c) which					
		xtent of a couple's					
	•	urces at the time of					
		n and attributes to the					
	• •	se an equitable share of					
		cannot be considered					
		ment toward the cost of the					
		pouse's medical care in his					
	•	spending down to					
	Medicaid eligibilit	y levels.					
	A neeting of name	on addresses and					
		es, addresses, and ers of all pertinent State					
	•	roups such as the State					
		cation agency, the State					
	•	he State ombudsman					
		ection and advocacy					
	. •	Medicaid fraud control unit;					
		that the resident may file a					
		e State survey and					
	•	cy concerning resident					
	•	nd misappropriation of					
		in the facility, and					
		with the advance directives					
	requirements.						
	The facility must						
		cified in subpart I of part					
		er related to maintaining					
	•	nd procedures regarding					
		es. These requirements					
	•	s to inform and provide					
		n to all adult residents					
		ght to accept or refuse					
	medical or surgic	al treatment and, at the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	/2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n, formulate an advance cludes a written description					
		•					
	of the facility's policies to implement advance directives and applicable State law.						
		эрригания стано					
		inform each resident of the					
		and way of contacting the					
	physician respon	sible for his or her care.					
	The facility must	prominently display in the					
	-	ormation, and provide to					
		plicants for admission oral					
		nation about how to apply					
		care and Medicaid benefits,					
		ve refunds for previous ed by such benefits.					
	payments covere	d by such beliefits.	F01	56	1. Residents # 42, #59 and #1	6	01/20/2013
	Based on reco	rd raviow and	101	30	have been discharged from	O	01/20/2013
					Medicare services. No adverse	е	
		acility failed to inform			affects were noted.2. Residen	ts	
		e services available in			being discharged from Medica	re	
	1	charges for such			services have the potential of		
		overed by Medicare			being affected by this alleged deficient practice. Business O	ffice	
	•	ed with their ABN			Manager (BOM) has been	IIICE	
	· `	icare Non-Coverage)			in-serviced on appropriate		
	-	rovide documentation			documentation for Notices on		
	_	ly notification of the			Medicare Non-Coverage (ABN		
		r 3 or 3 residents			including providing rates/charge		
	`	sidents #16, #42, and			obtaining a date from the pers signing the ABN and meeting		
	#59				required minimum of 2 day		
					notice.3. BOM has been		
	Findings include	le:			in-serviced on appropriate		
					documentation for Notices on		
	1) During reco	rd review on 12-17-12			Medicare Non-Coverage (ABN including providing rates/charge	,	
	at 10:10 AM, th	ne ABN's (Notices of			obtaining a date from the pers		
	Medicare Non-	Coverage) for Resident			signing the ABN and meeting		
	#42, Resident	#59, and Resident #16			required minimum of 2 day	-	
		any documentation			notice.4. Audits of the ABN's v		
		osts of services after			be done monthly x 6 months b	y	

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIH	LDDIC	00	COMPL	ETED
		155782		LDING		12/21/	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
\\/\ UTE		DUO		814 S 6			
WHILE	OAK HEALTH CAMI	P05		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the date of Nor	n-Medicare Coverage			Home Office Business Suppor		
	was reviewed with those residents.				person or designee.Audit resu	lts	
					will be brought to monthly		
	During an inter	view on 12-17-12 at			Quarterly Assurance (QA)	wod	
	•	ployee #1 (Business			meetings. Trends will be review by QA committee x 6 months of		
	Office Manager) stated she did not have documentation that a list of				until 100% compliance is	J1	
					achieved.		
	l •	were presented to					
		notice of being					
	discharged froi	m Medicare coverage.					
	2) During reco	ord review on 12-17-12					
	at 10:10 AM, th	ne ABN's (Notice of					
	Medicare Non-	-Coverage) did not					
		quired 2 day notice had					
	been given for	•					
		and Resident #16.					
	resident #55,	and resident #10.					
	The ADN for D	esident #42 indicated					
		ate of coverage for					
		nurses services ended					
		otification date of the					
		own as Resident #42					
	signed the form	n but did not date it.					
	The ABN for R	esident # 59 indicated					
	the effective da	ate of coverage of					
		ending on 8-8-12. The					
		e of the ABN was					
		esident #59 signed the					
	form but did n	· ·					
		or date it.					
	The ADM for D	looidont #16 indicated					
		esident #16 indicated					
		ate coverage of current					
	skilled nursing	services would end					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		155782	A. BUI B. WIN	LDING IG		12/21/	
NAME OF D	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
	OAK HEALTH CAME			<u> </u>	CELLO, IN 47960		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	9-21-12. The f	acility failed to give					
Resident #16 the required minimum							
		as Resident #16					
	signed the ABN	N ON 9-20-12.					
	3.1-4(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED	
		155782	B. WING		12/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF F	PROVIDER OR SUPPLIE	R		6TH ST	
WHITE C	OAK HEALTH CAM	PUS		ICELLO, IN 47960	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0176 SS=D	DEEMED SAFE An individual res drugs if the inter by §483.20(d)(2) practice is safe.	F-ADMINISTER DRUGS IF sident may self-administer disciplinary team, as defined l(ii), has determined that this ervation, interview and	F0176	Resident #67 no longer res     at facility.2. Residents receivir	
	record review, assess the res administration medications for reviewed for s	the facility failed to sident for self of respiratory or 1 of 1 residents		respiratory medications have potential to be at risk of allege deficient practice. Incorrect powas provided to state survey team during the time of the survey. Residents receving respiratory medications will be assessed for self medication administration. Any changes we	ed blicy
	reviewed on 1 Resident #67's but were not li fibrillation (irre hypertension, Obstructive Podementia.  The Quarterly Assessment, of indicated the re cognitively important	s clinical record was 2/13/12 at 2:49 p.m. s diagnoses included mited to, atrial gular heart beat), COPD (Chronic ulmonary Disease), and Minimum Data Set dated 09/13/12, resident's was paired.		be documented and implement accordingly.3. Licensed nurse will be in-serviced on Respiratory/Inhalation Treatm Guidelines which is the currer policy the facility follows. It indicates that "if a resident is stable receiving the treatment nurse does not need to remain the room during the entire administration of the treatment Director of Health Services (Dor designee will conduct respiratory treatment observations on various shifts 3x's/ week x 1 month, weekly month, then monthly monthly months. 4. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved	ent of the

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782		LDING	NSTRUCTION 00	COMP	E SURVEY LETED 1/2012
	PROVIDER OR SUPPLIER		<b>.</b>	814 S 6	ADDRESS, CITY, STATE, ZIP CODI TH ST CELLO, IN 47960	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	was observed #67's Levalbute nebulizer (brea (ordered 6/15/2 while the mach the breathing to the resident's for give medicate again. LPN #3 resident's room medication addreturning to Resident's room medicated to he she will be back. Interview with I indicated the resident while the was running.  On 12/14/12 at was observed #67's Levalbute nebulizer treatment mask LPN #4 was observed the coughing has treatment mask LPN #4 was observed with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the machine a.m. and the coughing has treatment mask LPN #4 was observed with the medicated the resident mask LPN #4 was observed with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the medicated the resident with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the medicated the resident with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the medicated the resident with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the medicated the resident with the machine a.m., Resident be coughing has treatment mask LPN #4 was observed with the medicated the resident with the machine a.m., Resident with the machin	LPN #3 at this time esident can be left enebulizer machine as 9:49 a.m., LPN #4 initiating Resident erol 1.25 mg/3 ml ment and left room was running. At 9:54 #67 was observed to ard while the breathing k was on the face. Oserved returning to the 20 a.m. before turning					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			э. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	12	DATE
	indicated the re	esident can be left					
	alone while the	e nebulizer machine					
	was running.						
	Δ facility policy	undated and provided					
	A facility policy, undated and provided by the Director of Nursing on						
		a.m., indicated					
		questing to self					
		is self medication as a					
	•	an of care shall be					
		afety by a licensed					
	nurse. Results	of the assessment will					
	be presented to	o the physician for					
	evaluation and	an order for self					
	administration.	"					
	A Specific Med	dication Administration					
	Procedures po	licy dated 2/1/10 was					
	•	e Consultant on					
	12/14/12 at 10						
		icated this was the only					
		ld find regarding					
		ne policy indicated					
		the resident for the					
		ss the resident has					
		d and authorized to					
		, approximately five					
		reatment begins (or					
	sooner if clinication	al judgement indicates)					
	obtain the resid	dent's pulse, monitor					
	for medication	side effects, including					
	rapid pulse, res	_					
	nervousness th						
	treatment.						
	a catinont.						

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Event ID: KGNH11

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155782	A. BUII B. WIN	LDING	00	COMPLETED 12/21/2012	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	AK HEALTH CAMF			814 S 6 MONTIC	TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	'E	(X5) COMPLETION DATE
	REGULATORY OR  The December	2012 Physician Orders did not indicate a sable to self			CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155782	B. WIN			12/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6			
WHITE O	AK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG F0241		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
SS=D	•	promote care for residents					
		in an environment that					
		ances each resident's ct in full recognition of his y.					
	Based on obse	rvation and interview,	F02	41	1. Resident #95 received his		01/20/2013
	the facility faile	d to ensure all			lunch during the time of the		
	residents had b	peen served lunch prior			survey. He ordered a "special"		
		od from the serving			that was prepared in the kitche and, therefore, didn't need to	en	
	•	I to ensure a resident			receive any food from the stea	m	
	was in clean pa	ants prior to going to			table. Resident #24 was provide		
		of 6 residents observed			clean pants during the time of		
		esident #24 and #95)			survey. No adverse affects we noted.2. Residents receiving	re	
	Findings includ	e:			meals in the dining room have potential to be affected by the alleged deficient practice. Diet		
	1. Lunch servi	ce was observed on			and Nursing staff will be	-1-	
	12/11/12 from	12:30 to 1:00 p.m.			in-serviced on verifying resider present in the Dining Room	าเร	
	Resident #95 v	vas observed sitting at			receive their food before the fo	od	
	his table withou	ut his lunch. Resident			is removed. Nursing staff will a		
	#95 indicated h	ne had not received his			be in-serviced on dignity issue	S	
	lunch and ques	stioned when he would			related to residents' hair being		
	receive it. Diet	ary and CNA#8 was			combed and clothing not being soiled. 3. Meal Manager or	)	
	observed to be	removing food from			designee will conduct audits		
	the steam table	e and dishes from other			3x's/week x 1month, then wee	kly	
	resident tables	. Interview with CNA			x 5 months to ensure all reside		
	#8 during this t	ime indicated she was			in the Dining Room receive for		
	not aware the r	esident had not			prior to food being removed ar that residents are in unsoiled	iu	
	received his lur	nch due to his lunch			clothing with combed hair. 4.		
	ticket was not	available.			Audit results will be brought to		
	2. On 12/13/12 Resident #24 w	2 at 8:30 a.m., vas observed in her			monthly Quality Assurance (Quality Meetings. Trends will be review by QA Committee x 6 months until 100% compliance is	wed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION 155782	NUMBER:	A. BUILDING  B. WING	00	COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS		814 S	T ADDRESS, CITY, STATE, ZIP CODE 6 6TH ST TICELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DE (EACH DEFICIENCY MUST BE PRE- REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	wheel chair in the front lour her hair not combed and passoiled/stained in between here assisted to the Dining Roor breakfast and then returned Lounge. Resident was obsequent was obsequent with consideration of the cons	ants her legs. I being m for d to Unit served at s on. ng this time		achieved.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet Page 13 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6			
WHITE O		ni ie			CELLO, IN 47960		
VVIIIE	AK HEALTH CAMF	-03		MONTH	GELLO, IN 47900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0250 SS=D	483.15(g)(1) PROVISION OF ITS SOCIAL SERVICE The facility must provide social services to highest practicable psychosocial well Based on reconsinterview, the facility must provide social services care related to reviewed with our without the service of stealing his to social services care related to reviewed with our without the service of stealing his to social service service service service service of stealing his to social service	MEDICALLY RELATED E provide medically-related attain or maintain the e physical, mental, and being of each resident. The review and acility failed to ensure assisted with planning 1 of 1 resident delusions. (Resident delusions.)  The review on 12/14/12 at atted Resident #46's added, but were not entia with behavioral depression, with a state of the reported that he enursing home is the land prostitution. The also expressed to this writer. In quently accuses staff	F02		1. Social Services Director (SS developed care plans related to delusions and false accusation for Resident # 46 at the time of the survey. No adverse affects were noted.2. Residents exhibiting delusions and/or false accusations have potential for alleged deficient practice. SSE designee will review all charts current residents to ensure the exhibiting delusions and/or false accusations have care plans.3 SSD will be in-serviced on the necessity of care plan documentation related to delusions and/or false accusations. 4. Minimum Data Set Coordinator (MDSC) or designee will audit care plans in place for residents exhibiting delusions and/or false accusations in conjuction with care planning schedule. MDSC will audit with each MDS due date. Audit results will be broug to monthly Quaility Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliar is achieved.	SD) o o o o o o o o o o o o o o o o o o o	DATE 01/20/2013
			1		i .		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			Б. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R		814 S 6			
WHITE C	OAK HEALTH CAME				CELLO, IN 47960		
VVIIIIL	AKTILALTIT CAWI			WONTR	SELEO, IN 47 900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated Resid	dent #46 had thought					
	processes with	"occasional paranoid					
	delusions." Th	ne consultation					
	recommended a goal for Resident						
	#46 to continue	•					
		(which began on					
		5 mg a.m. and 50 mg					
		h "no change at					
	•	oilize mood and avoid					
	any increase ir	n psychosis."					
		cord review indicated					
	that Resident #	#46 had a care plan for					
	psychotropic d	rug use (dated					
	6/20/12), psycł	nosocial problems					
	(11/13/12), imp	paired decision making					
	, , ,	tive function (9/7/12),					
		13/12), communication					
		behavior (6/13/12)					
	(0/13/12), and	beliavior (6/15/12)					
	The same when t						
	•	lacked documentation					
		resident had delusions					
	and/or false ac	cusations.					
	On 12/17/12 at	t 11:01 A.M. during an					
	interview with t	he Social Service					
	Director (Emple	oyee #2), she indicated					
		not been care planned					
		it it should have been.					
		it it offodia flavo booff.					
	3 1 34(3)						
	3.1-34(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00		LETED			
		155782	B. WING			/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE			
			•			•			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet Page 16 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILIDING	00	COMPLETED
		155782	A. BUILDING		12/21/2012
			B. WING		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
			814 S 6		
WHITE O	AK HEALTH CAMP	PUS	MONTI	CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F0272	483.20(b)(1)	· · · · · · · · · · · · · · · · · · ·			
SS=D	, ,, ,	VE ASSESSMENTS			
00-D		conduct initially and			
	•	nprehensive, accurate,			
		oducible assessment of			
	·	inctional capacity.			
	A facility must ma	ake a comprehensive			
		resident's needs, using the			
		ent instrument (RAI)			
		State. The assessment			
	must include at le	east the following:			
		demographic information;			
	Customary routing				
	Cognitive patterns	s;			
	Communication;				
	Vision;				
	Mood and behavi				
	Psychosocial well				
	Physical functioni	ing and structural			
	problems;				
	Continence;	a and backth conditions:			
	Dental and nutrition	s and health conditions;			
	Skin conditions;	oriai Status,			
	Activity pursuit;				
	Medications;				
		ts and procedures;			
	Discharge potenti				
		f summary information			
		litional assessment			
		care areas triggered by			
		the Minimum Data Set			
	(MDS); and				
	Documentation of	f participation in			
	assessment.				
	Based on recor	rd review and	F0272	1. Resident #33 has had upda	ted 01/20/2013
	interview, the fa	acility failed to		Minimun Data Assessment	
		accurately assess		(MDS) and care plans updated	d.
	0 ,	<u> </u>		Resident #35 will have	
		the MDS (Minimum		Elimination Circumstance Forr	n
	Data Set) Asse	essments, related to	1	initiated and updates will be m	ade
			L		ı

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Event ID: KGNH11

Facility ID: 012355

If continuation sheet Page 17 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.c	00	COMPL	ETED
		155782	A. BUII			12/21/	
		1 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3 -	B. WIN	_			= - · <b>=</b>
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE C	OAK HEALTH CAM	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	pressure ulcer	s and urinary			accordingly. Residents #33 ar	nd	
	incontinence, f	for 2 of 19 residents			#35 had no adverse affects		
	reviewed for a	ssessments. (Residents			related to alleged deficient		
	#33 and #35)	•			practice. 2. Residents with	in	
	moo ana moo,				pressure ulcers and changes	III	
	Finalinana in alco	J.,			urinary incontinence have potential of being at risk of		
	Findings include	JE.			alleged deficient		
					practice. Pressure ulcer		
	1. Resident #3	3's record was			documentation will be compar	red	
	reviewed 12/12	2/12 at 5:30 p.m The			to Minimum Data Assessmen		
	resident's diag	noses included, but			(MDS) coding for current		
	_	d to, failure to thrive			residents that have pressure		
	and congestive	·			ulcers.Corrections to MDS wil	l be	
	and congestive	e fleatt failure.			sumbitted as necessary. Any		
					residents who experienced a		
	_	MDS Assessment,			change in incontinence based		
	dated 09/04/12	2, indicated the resident			MDS Assessments and feedb		
	had one stage	one (intact skin with			from nursing staff within the la		
	non-blanchabl	e redness) pressure			30 days will have documentat	ion	
		stage two (partial			reviewed to ensure an	£	
		of dermis) pressure			assessment was completed. I		
					assessment is not documente one will be completed. 3. Wou	•	
	•	nstagable pressure			nurse or designee will be	inu	
	areas.				in-serviced on appropriate		
					documentation protocol and		
	The care plan	, dated 07/30/12,			assessment of pressure ulcer	S.	
	indicated the r	esident had a pressure			Nursing staff including Minimu		
	ulcer on the rig				Data Set Assessment		
	•	ncluded to assess the			Coordintaor (MDSC) will be		
					in-serviced on necessary		
	pressure area	per scriedule.			assessment documentation w		
					changes in urinary incontinen	ce.	
		Ulcer Assessment			Certified Resident Caregiver		
	form, indicated	I the assessment size			Associates (CRCA's) will		
	of the right hee	el pressure ulcer, during			communicate increased episo		
	_	ssment period, on			of incontinence to the nurse w	/no	
		a stage two (the stage			will initiate an Elimination	or.	
		, ,			Circumstance Form. If necess a 72 hour Elimination	oaiy,	
		marked over and an "E"			Record/Schedule will also be		
	i (unstagable) w	as written over it. The			I record/scriedule will also be		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155782				12/21/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		DI IO		814 S 6		
WHILE C	OAK HEALTH CAMI	PUS		MONTI	CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	size was 4 cm	(centimeters) by 7 cm			inititated to determine patterns	of
	with a depth of	0.2 cm. The color of			incontinency and if a toileting	
		s marked as, "R (red)/P			schedule will prevent	
		low) (slough)", and had			incontinency.4. MDSC and wo	
	'' ' '	, ,			nurse or designees will compa	•
	irregular wound	u maryins.			pressure ulcer documentation MDS coding at time of	10
					MDS reference period for all	
	_	view on 12/13/12 at			residents with pressure ulcers	to
		S LPN indicated the			ensure accuracy x 6	
	assessment of	wound was marked			months. DHS or designee will	
	with as a stage	e two by the nurse who			ensure any residents	
	assessed it an	d another nurse			experiencing changes in urina	
	marked over it	and coded it			incontinence have an Eliminat	
		"). She indicated the			Circumstance Form completed	•
	,	as not correct, but the			with each change identified. The	nis
		he form occurred after			will be done 5 x's/week x 1	ath
					month, then 3x's/week x 1 mon then weekly x 4 months. Audit	
	she had compl	leted the MDS			results will be brought to Quali	
	Assessment.				Assurance (QA) meetings	7
					monthly. Trends will be review	ed
	2. Resident #3	35's record was			by QA Committe x 6 months o	r
	reviewed on 12	2/17/12 at 11:30 a.m.			until 100% compliance is	
	The resident's	diagnoses included,			achieved.	
		mited to hypertension				
	and dementia.					
	ana domonida.					
	The Admissis	MDS Assessment				
		n MDS Assessment,				
		2, indicated the resident				
	was continent	of urine.				
	A Significant C	change MDS				
	Assessment, d	lated 10/22/12,				
		esident was frequently				
	incontinent of u					
	There was a la	ick of documentation				
	an assessmen	t had been completed				

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Event ID: KGNH11

Facility ID: 012355

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782	LDING	NSTRUCTION  00	(X3) DATE COMPL 12/21/	ETED
	PROVIDER OR SUPPLIER		STREET A 814 S 6	ADDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	with the Significant Charles and been compressional to the incontinency, processing the incontinency, and to the incontinency.	cant Change MDS indicate the reason for cy, type of patterns of and for a personal	IAU			DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155782	B. WING			12/21/	2012
			B. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6			
WHITE O	OAK HEALTH CAME	0110			CELLO, IN 47960		
	ARTILALITI CAMI			WONT	SELEO, IN 47 900		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.20						
SS=E		PREHENSIVE CARE					
	PLANS	- 4l					
		e the results of the evelop, review and revise					
		nprehensive plan of care.					
	the resident's con	ilprenensive plan of care.					
	The facility must o	develop a comprehensive					
		resident that includes					
		ctives and timetables to					
	meet a resident's	medical, nursing, and					
		osocial needs that are					
	identified in the co	omprehensive assessment.					
	The care plan mu	st describe the services					
	•	nished to attain or maintain					
		nest practicable physical,					
		hosocial well-being as					
		183.25; and any services					
		vise be required under					
		ot provided due to the					
	resident's exercis	e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).						
			F027	79	1.Care plans were developed		01/20/2013
	Based on obse	rvation, interview and			Residents #12, #28, #36, #40,		
	record review,	the facility failed to			#46, #51 and #57. No adverse		
	develop care p	lans for 6 out of 10			affects were noted.2. Resident		
		wed for unnecessary			who take medications known to thin blood and possibly cause	J	
	medications wh	•			bruising and residents who ext	nihit	
		own to thin the blood			delusions and/or false		
					accusations have potential of		
	•	ause bruising and 1 of			being at risk of alleged deficier	nt	
		iewed for behaviors.			practice. Care plans of residen		
	(Residents #12	2, #28, #36, #40, #46,			with these factors have been		
	#51, and #57)				reviewed. Care plans have bee	en	
					initiated accordingly. All new		
	Findings includ	e:			admissions and residents with		
	<b>3</b>				medication changes will have	alv.	
	1 Resident #3	6's clinical record was			care plans developed according in compliance with due date of		
	1. INCOIDEIR#3	o a cillical recolu was	1		in compliance with due date of		

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	LDING	00	COMPLI	ETED
		155782	B. WIN			12/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	8		814 S 6	TH ST		
	OAK HEALTH CAMI			MONTI	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ГЕ	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	•	204	DATE
TAG	reviewed on 12 Resident #36's but were not lir obstructive pul steroid induced and anemia.  The 12/2012 P orders indicate prednisone (ste (milligrams) an (antiplatelet/ble daily basis.  During an inter on 12/11/12 at were observed bilateral hands indicated she h bruises all the  Interview with to on 12/14/12 at indicated there sheets/assessi	rview with Resident #36 2:15 p.m., bruises on the top of her . The resident had lupus and she gets time.  the Nurse Consultant 10:30 a.m., she were no skin ments found in a ider located at the		TAG	care plans.3. Minimum Data S Assessment Coordinator (MDS and Social Services Director (SSD) will be in-serviced on necessity of developing care plans for residents with these factors. MDSC will review diagnosis' and behavior coding on MDS in comparison to care plans at the time of each MDS Director of Health Services (Di or designee will audit that care plans are in place for residents who take medications known to thin blood and possibly cause bruising and residents who exi- delusions and/or false accusations occur and/or new onset of delusions and/or false accusations occur and/or with new admissions. 4. Audit resu will be brought to monthly Qua Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	Get SC) HS) So hibit	DATE
	documentation resident had a	dated 11/27/12, lacked to indicate the care plan for the d Plavix therapy and sing.					
	2. Resident #1	12's clinical record was					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155782	B. WIN			12/21/2	012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ТЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 12	2/17/12 at 11:00 a.m.					
	Resident #12's	diagnoses included					
	but were not limited to,						
	arteriosclerosis	s, chronic right leg pain,					
		obstructive pulmonary					
	`	, PVD (peripheral					
		se), CVA (cerebral					
		ent/stroke) with					
	hemiplegia (pa	•					
		ression fracture.					
	Vertebrai comp	ression fracture.					
	The 12/2012 D	hysician Recapitulation					
		ed the resident took					
		or DVT (deep vein					
		, .					
		od clot) on a daily					
	basis.						
	The care plan	dated 08/14/12, lacked					
		·					
	documentation						
		care plan for the Plavix					
	therapy and the	e risk of bruising.					
	0 Decident #5	710 oliminal masses					
		57's clinical record was					
		2/17/12 AT 2:00 p.m.					
		diagnoses included					
		mited to Parkinson's					
		(coronary artery					
	disease), anen	nia, and arthritis.					
		hysician Recapitulation					
		d the resident took					
	Plavix 75 mg d	aily for anti-platelet and					
	aspirin 325 mg	two times daily for					
	heart health.	-					
	I		ı				

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155782	B. WING	3		12/21/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	ROVIDER OR SOLI EIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A care plan wa	s initiated 9/18/12 for					
	the resident be	eing at risk for bleeding					
	related to antic	coagulant use, but this					
	care plan was	discontinued with an					
	unknown date.						
		t 11:00 a.m., the					
	resident was o	bserved to have nickel					
	size bruises lo	cated on the inner part					
	of her bilateral	upper arms.					
	•	dated 09/18/12, lacked					
	documentation	to indicate the					
	resident had a	care plan for the					
	aspirin and Pla	vix therapy and the risk					
	of bruising.						
	Interview with t	the MDS (Minimum					
	Data Set) LPN	on 12/14/12 at 11:15					
	a.m. indicated	she had never					
	considered res	idents who take					
	•	avix, or aspirin as a					
	possible blood	thinning agent and has					
	never wrote ca	re plans for them. She					
	indicated the m	nedications can cause					
	bruising. She i	indicated the care plan					
	was discontinu	ed when the resident's					
	Coumadin (blo	od thinner) was					
	discontinued.						
	_	oservation on 12/11/12					
		Resident #51 was					
		ive a bruise on the					
	back of her left	hand.					

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
		l .		STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	t.		814 S 6	TH ST		
WHITE O	AK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	CHMMADVC	TATEMENT OF DEFICIENCIES		ID	·		(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
TAG		· · · · · · · · · · · · · · · · · · ·		TAG			DATE
		record was reviewed					
		3:30 p.m The					
	_	noses included, but					
	were not limite	d to, hypertension and					
	stroke.						
	A Skin impairm	nent circumstance					
	•	lated 2/7/12, indicated					
	,	id a bruise on the back					
		nd, which measured 5					
	_	s) by 5.5 cm. The					
	`	the bruise was caused					
	by a blood drav	w for a laboratory test.					
	,	s Recapitulation					
	•	12/12, indicated the					
	resident was re	eceiving ASA (aspirin)					
	81 mg (milligra	ms) daily.					
	The care plan,	dated 11/05/12, lacked					
	documentation						
		care plan for the					
		and the risk of					
	bruising.	and the fisk of					
	bruising.						
	During on inter-	niou on 19/14/49 of					
	_	view on 12/14/12 at					
	•	MDS LPN indicated					
		o a care plan for					
	-	ated, "in my opinion, it					
	is a low dose o	f aspirin and is not a					
	risk for bleedin	g". She indicated she					
	had not consul	ted with the pharmacy					
		ng aspirin daily.					
		. ,					
	A Profession R	Resource, titled, "2010					
		, ,	1				

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		155782	B. WING	NO		12/21/	2012
				TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		314 S 6			
WHITE C	OAK HEALTH CAM	PUS			CELLO, IN 47960		
					<u> </u>		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	ſAG	DEFICIENCY)		DATE
	Nursing Spect	rum Drug Handbook"					
	indicated,						
	"ASAConti	raindicationsHemorrh					
	agic states or	blood coagulation					
	_	ware that aspirin should					
		ed at least 1 week					
		because it inhibit					
		gationAdverse					
	reactionsbru	lising"					
	_	observation on					
		13 a.m., Resident #28					
	was observed	to have a purple					
	discoloration of	on her left lower leg.					
	During an inte	rview at the time of the					
	_	Resident #28 indicated					
	· ·	are of what caused the					
	purple discolo						
	purple discolor	idion.					
	During on ohe	omistion on 12/12/12 of					
	_	ervation on 12/13/12 at					
		oruise was observed on					
		right upper arm. The					
	resident indica	ated she did not know					
	how the bruise	e occurred.					
	Resident #28's	s record was reviewed					
	on 12/14/12 at	t 8:19 a.m. The					
		noses included, but					
	·	ed to, Parkinson's					
	Disease and s	-					
	Disease and s	DUUNE.					
	•	's Recapitulation					
		12/12, indicated the					
	resident receiv	ved aspirin 81 mg daily.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARVS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		care plan, dated		1110			5.112
		-					
	· ·	ed documentation of					
		and the risk for					
	bruising.						
	6. Resident #4						
		2/14/12 at 2 p.m. The					
	_	noses included, but					
		d to, stroke and					
	hypertension.						
	•	s Recapitulation					
	•	12/12, indicated an					
	order on 08/25	/12 for Plavix					
	(anti-blood clot	tting medication) 75 mg					
	daily.						
	-						
	The resident's	care plan, dated					
	11/09/12, lacke	ed documentation to					
	· ·	sident was receiving					
		and the risks from the					
	medication.						
	During an inter	view on 12/17/12 at					
	_	MDS LPN indicated					
	· · · · · · · · · · · · · · · · · · ·						
		are plan for the Plavix					
		s like aspirin it is low					
		was no problems or					
	risks with takin	g it.					
	A 5 1111 - 5- 5	and an all Da					
	•	ssional Resource,					
	,	Drug Handbook 2012",					
	indicated, "Pla	vixADVERSE					
	REACTIONS	.bruising"					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLI	
		155782	B. WIN	G		12/21/	2012
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE	OAK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		cord review on 12/14/12		IAG	,		DATE
		dicated Resident #46's					
		diagnoses included, but were not					
	limited to dementia with behavioral						
	disturbances, o	depression,					
		ystitis, Alzheimer's, and					
	stroke.						
		lealth Consult, dated					
	<u> </u>	ed, "staff reports that					
	,	ne) is having difficulties					
		. He reported that he					
		ne nursing home is					
	_	hel and prostitution He also expressed					
		s to this writer. In					
		equently accuses staff					
	of stealing his						
		90.					
	A psychiatry co	onsultation on 4/25/12					
	indicated Resi	dent #46 had thought					
	processes with	"occasional paranoid					
	delusions." T	he consultation					
		a goal for Resident					
	#46 to continue						
	, , , , , , , , , , , , , , , , , , ,	(which began on					
		5 mg a.m. and 50 mg					
	·	th "no change at					
	•	pilize mood and avoid					
	any increase ir	i psychosis.					
	The clinical red	cord review indicated					
		#46 had a care plan for					
		rug use (dated					
	1	hosocial problems					

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155782	A. BUII B. WIN	LDING	00	COMPL: 12/21/	ETED
NAME OF F	AD CLUDED OD CLUDALIED		B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER			814 S 6			
	OAK HEALTH CAMP			MONTIC	CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	(11/13/12), imp (9/7/12), cognit depression (6/1 (6/13/12), and I The care plan I to indicate the i and/or false acc On 12/17/12 at interview with the Director (Employed)	aired decision making ive function (9/7/12), (3/12), communication behavior (6/13/12) acked documentation resident had delusions					

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Event ID: KGNH11

Facility ID: 012355

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0280 SS=D	CARE-REVISE Of The resident has incompetent or or incapacitated und participate in plan changes in care at the A comprehensive developed within of the compreher by an interdisciple the attending phy with responsibility appropriate staff by the resident's practicable, the participate the resident's practicable, the participate of the resident's fand revised by a after each assess Based on reconstruction, oxygen of 19 residents plans. (Residents plans. (Residents plans.) (Residents plans included the resident's but were not line and kidney dis	the right, unless adjudged therwise found to be der the laws of the State, to ming care and treatment or and treatment.  To days after the completion asive assessment; prepared inary team, that includes visician, a registered nurse of for the resident, and other in disciplines as determined needs, and, to the extent participation of the resident, hilly or the resident's legal and periodically reviewed team of qualified persons sment.  To review and facility failed to revise are plans related to dies, medications, en, and oral care for 2 areviewed for care ants #13 and #95)	F0280	1. Residents #13 and #95 no longer reside at the facility.2. Care plans of current resident related to dialysis and nutritior will be reviewed for accuracy. updates will be made as necessary. 3. Minimum Data Set Assessment Coordinator (MDSC) will be in-serviced on developing accurate care plans based on choosing correct care plan typand non-compliance of physician's orders by family or resident.4. Care plans will be updated as needed and audite by MDSC with each MDS x 6 months.Director of Health Services (DHS) or designee waudit that updated care plans	n Any ee		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI	LTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
MADILAN	of condition	155782	A. BUILE B. WING			12/21/	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEI	R		814 S 6			
WHITE C	OAK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	P	REFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG	The Admission dated 11/26/12 had a right clarvein) dialysis at A care plan, dathe resident had (arterial/ventric access site) armonitor the brofistula).  During an interfect of the monitor that are sident had at 2. Resident # reviewed on 12 Resident's #13 but were not libertal insufficies. A care plan was and updated 9 interventions in monitor for significations in the plant of t	n Nursing Assessment, 2, indicated the resident vicle subclavian (large access site.  ated 12/05/12, indicated ad an AV cle) fistula (dialysis and the staff were to uit/thrill (vibration of the access site).  Tyiew on 12/17/12 at Minimum Data Set dicated she thought the fistula.  The dicated she thought the acceptance included and chronic acceptance included and chronic acceptance included acceptance in		IAG	are completed with new physician's orders 5 x's/week x month, then 3x's/week x 1 morand then weekly x 4 months. Audit results will be brought to monthly Quality Assurance (Queetings. Trends will be review by QA Committee x 6 months until 100% compliance is achieved.	nth A) wed	DATE

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:  155782	A. BUILDING B. WING		00	COMPL 12/21/	ETED
	PROVIDER OR SUPPLIER	us	814	S 61	DDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	done on 8/23/12 indicated a plate (low). Normal r A CBC was dor results indicated count of 287.  The care plan windicating the results or supplements or	elet count of 118 L ange was (150-450). ne on 6/25/12. The d a normal platelet					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPL		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155782	B. WING		12/21/2012	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .	814 S 6	6TH ST		
WHITE C	OAK HEALTH CAME	PUS		ICELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG F0282		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
SS=D	CARE PLAN The services proving facility must be propersions in according to the control of the c	WALIFIED PERSONS/PER  vided or arranged by the rovided by qualified dance with each resident's				
	physician's ord related to fluid residents reviee (Residents #57)  Findings included 1. Resident #9 reviewed on 12 The resident's but were not limited and kidney discondicated to limited to one liter (10) (cc) per day.  The resident's following daily 12/08/12-1440 12/09/12-1710 12/10/12-1380 12/11/12-1120 12/12/12-1140 12/13/12-1230	rd review and acility failed to ensure lers were followed, restriction for 2 of 2 wed for fluid restriction. Tand #95)  le:  05's record was 2/17/12 at 8:28 a.m. diagnoses included, mited to, renal dialysis ease.  order, dated 12/07/12, hit the resident's fluids 00 cubic centimeters)  fluid intake record the intakes:  cc  cc  cc  cc  cc  cc  cc  cc  cc	F0282	1. Physician has been notified regarding non-compliance with fluid restriction for Resident #8 Resident #95 no longer resident the facility. No adverse affects were noted.2. Residents with physician orders for fluid restriction have potential to be risk of alleged deficient practice. Charts of current residents with physician's order for fluid restriction will be reviewed for compliance and appropriate documentation. S Determination of Care forms who are non-compliant.3. Nur staff will be in-serviced on pol for Guidelines for Fluid Restriction. Nurse will docume any non-compliance related to physician orders and notify Dror designee.4. DHS or design will review fluid consumption feach resident with physician's order for fluid restriction 5 x's/week x 2 weeks, then 3x's/week for 2 weeks, weekly months, then monthly x's 3 months to ensure compliance Audit results will be brought to monthly Quality Assurance (Comeetings. Trends will be review by QA Committee x 6 months	h 57. es at 57. es at 58. es at 58. es at 58. es at 59.	
	but were not lir and kidney disconding to one liter (100 (cc) per day.  The resident's following daily 12/08/12-1440 12/09/12-1710 12/10/12-1380 12/11/12-1120 12/12/12-1140	mited to, renal dialysis ease.  order, dated 12/07/12, not the resident's fluids 100 cubic centimeters)  fluid intake record the intakes:  cc  cc  cc  cc  cc  cc  cc  cc  cc		Determination of Care forms who are non-compliant.3. Nur staff will be in-serviced on pol for Guidelines for Fluid Restriction. Nurse will docume any non-compliance related to physician orders and notify DI or designee.4. DHS or design will review fluid consumption feach resident with physician's order for fluid restriction 5 x's/week x 2 weeks, then 3x's/week for 2 weeks, weekly months, then monthly x's 3 months to ensure compliance Audit results will be brought to monthly Quality Assurance (Comeetings. Trends will be reviewed to policy and the surface of the surface o	will s sing icy ent O HS ee for S V X 2  . O DA) ewed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	00	COMPL	ETED
		155782	B. WING			12/21/	2012
		1		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	ER		814 S 6			
WHITE C	OAK HEALTH CAM	1PUS			CELLO, IN 47960		
						1	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG		<u> </u>		IAG	,		DATE
	12/15/12-1660				achieved.		
	12/16/12-1224	4 cc					
	_	erview on 12/17/12 at					
	•	N #11 indicated the					
	resident can h	nave 90 cc of fluid with					
	each medicati	on pass. She indicated					
	the CNA's kno	ow the resident is on a					
	fluid restriction	า.					
	During an inte	erview on 12/17/12 at					
	_	Dietary Manager					
	-	resident received 213					
	cc's per meal.						
	ccs per mear.						
	An undeted fo	scility policy, received					
		icility policy, received					
		inistrator as current on					
		11 p.m., titled,					
		r Fluid Restriction",					
	· ·	Fluid consumption shall					
	be reviewed e	each shift to determine					
	adjustments n	ecessary in the fluid					
	intake of the r	esident on the					
	restriction in o	order to meet their					
	established flu						
		7's clinical record was					
		/17/12 at 2:00 p.m.					
		diagnoses included but					
		_					
		d to Parkinson's Disease,					
	,	artery disease), anemia,					
	and arthritis.						
	The 12/2012 Ph	nysician Recapitulation					
	orders indicated	I the resident was on a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SI	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	TED
		155782	B. WIN		-	12/21/2	012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	t .		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMADVS	TATEMENT OF DEFICIENCIES	I	ID	·	- 1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		ers) fluid restriction.		0			BIIIE
		ers) fluid restriction.					
	A care plan was initiated on 9/18/12						
		ident was at risk for					
	dehydration rela	ted to a fluid restriction.					
	The intervention	s indicated a 1000 ml					
	(milliliters) fluid	l restriction per day.					
	On 12/18/12 at 8	3:45 a.m., an interview					
		Manager indicated she					
	I -	munication form					
	_	nuch fluid was to be					
	_	ich meal. During this					
		•					
		ommunication form was					
		starting date of 3/3/12					
	indicating 220 m	nl with each meal and 80					
	ml "x 4 med (me	edication)" passes.					
	An intake record	l was reviewed on					
	12/18/12 at 12:3	0 p.m. Between 10/14/12					
		resident had consumed					
		fluid for 14 out of 18					
		11/1/12 to 11/30/12, the					
	1 -	sumed over 1000 ml of					
		of 30 days. Between					
		/12, the resident had					
		1000 ml of fluid 13 out of					
	17 days.						
	An interview wi	th the ADON (Assistant					
		ing) during this time					
		ident was non compliant					
		striction and there should					
		on by the staff when the					
	oe documentatio	n by the start when the					

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Facility ID: 012355

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF I	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
Will Of 1	KO VIDEK OK SOI I EIEI			814 S 6			
WHITE C	OAK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident was no	n compliant.					
		ord lacked documentation					
	to indicate the resident was						
	non-compliant w	with the fluid restriction.					
	An undated fac	cility policy, received					
	from the Admir	nistrator as current on					
	12/17/12 at 2:1	1 p.m., titled,					
	"Guidelines for	Fluid Restriction",					
	indicated, "Fl	luid consumption shall					
	be reviewed ea	ach shift to determine					
	adjustments ne	ecessary in the fluid					
	intake of the re	esident on the					
	restriction in or	der to meet their					
	established flui	id needs"					
	A Guideline for	Fluid Restriction was					
	provided by the	e Administrator on					
		00 p.m. The guidelines					
		take and output					
		II be initiated upon					
	receipt of the c	•					
		hall be reviewed by					
	-	ne adjustments					
		ne fluid intake of the					
		restriction in order to					
		iblished fluid needs.					
	Should the res						
		rty chose not to comply					
	with the recom						
		elf Determination of					
	· ·						
	Care form should be completed explaining the risk(s) of						
		e. If the resident and/or					
	<sub>l</sub> noncompliance	. II the resident and/of	1				I

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If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				00	COMPL		
		155782	A. BUI B. WIN	LDING G		12/21/	
NAME OF P	PROVIDER OR SUPPLIER	,	J. 7711V		ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		rty continues to refuse					
		care intervention after					
	the risk(s) have	e been explained, an					
	order should be						
		e fluid restriction. The					
		d be periodically ppropriateness and					
		d for fluid restriction"					
	3.1-35(g)(2)						

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Event ID: KGNH11

Facility ID: 012355

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING	· <del></del> -	12/21/2012
NAME OF I	DOMED OF CHIRD IED		STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		814 S	6TH ST	
	OAK HEALTH CAME	PUS	MONT	ICELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0309 SS=D	must provide the services to attain practicable physic psychosocial well the comprehensive care.  Based on obse and interview, the provide necess related to dialy of 2 resident restrictions (#9 for 1 of 2 reside management (I checking a pulsadministration observed for dialy observed for dialy observed for dialy attaining the checking a pulsadministration observed for dialy of the checking a pulsadministration observed for dialy of the checking a pulsadministration of the checking a pulsa	BEING Ist receive and the facility necessary care and or maintain the highest cal, mental, and -being, in accordance with re assessment and plan of rvation, record review the facility failed to cary care and services, sis management for 1 viewed for fluid 5), pain management ents reviewed for pain Resident #12), and se prior to medication for 1 of 1 residents	F0309	1. Resident # 95 no longer resides at facility. Resident #5 had no adverse affects noted. Resident #12 had no adverse affects noted. Resident #12 w have a pain assessment completed.2. Residents receiving restriction, residents receiving medications that require check a pulse prior to administration residents experiencing pain had the potential to be at risk of alleged deficient practice.	ill ving th king and
	Findings includ  1. Resident #9 reviewed on 12 The resident's but were not lin and kidney dise was admitted in 11/26/12.  The Admission dated 11/26/12			Residents receiving dialysis services will have vascular access site assessed and documented. Nurses will document on Treatment Administration Records (TARs that access site has been assessed. Charts of current residents with physician's order fluid restriction will be reviewed for compliance and appropriate documentation. Physician will be notified of non-compliance. Medication observation audits will be conducted on residents received medication that requires a pul	ing

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLE	TED
		155782	B. WIN			12/21/2	2012
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L		814 S 6			
WHITE C	OAK HEALTH CAME	DIIS			CELLO, IN 47960		
	ARTICALITIOAM						
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	,		DATE
	vein) dialysis a	ccess site.			prior to administration by Direc	ctor	
					of Health Services (DHS) to		
	A. The dialysis	s care plan, dated			ensure compliance.Residents receiving prn pain medications		
	12/05/12, indicated the staff were to				will have Medication	'	
	monitor for con	nplications following			Adminstration Records (MAR)	s I	
		or fluid restrictions as			reviewed for use or prn pain		
	_	monitor vascular			medications. After review of		
	access site for				MARs, DHS or designee will		
					determine if a Pain Assessme		
		age, bleeding, and			and Circumstance Form will be		
	dressing.				initiated for 72 hours monitoring	9	
					of pain for each resident. Physician will be notified as		
	The Nurses' No				necessary.3. Nurses will be		
	Medication/Tre	atment Administration			in-serviced on Guidelines for		
	Records, dated	d 11/12 and 12/12,			Dialysis Provider Communicat	ion.	
	lacked docume	entation the resident's			Nursing staff will be in-service		
	vascular acces	s site, and condition			on policy for Guidelines for Flu		
		assessed prior to or			Restriction. Nurse will docume	_	
		the resident from			any non-compliance related to		
	dialysis.	the resident from			physician orders and notify		
	ulalysis.				physician. Nursing staff will be in-serviced on following orders		
	D	- days 40/47/40 - t			indicated related to taking puls		
	_	view on 12/17/12 at			prior to medication administrat		
	-	#11 indicated the			as indicated.Nursing staff will I		
	_	nicated with the dialysis			in-serviced on Guidelines for F	Pain	
	center over the	phone or they will			Assessment and Management		
	send a fax if th	ere is new orders. She			Director of Health Services (Di		
	indicated there	were no assessments			or designee will review TARs of	ot	
	completed by t	he staff before or after			residents receiving dialysis services 3x's/week x 1 month,		
		es to dialysis. She			then weekly x 5 months.DHS		
	indicated she r	-			designee will review fluid	<i>"</i>	
		sing in intact on the			consumption for each residen	t l	
		he indicated if the staff			with physician's orders for fluid		
					restriction 5x's/week x 2 weeks		
		g the access site, it			x's/week for 2 weeks, weekly >		
	would be docu				months, then monthly x 3 mon		
		ministration Record,			to ensure compliance.Medicat		
	then indicated	the access site had not	1		pass audits will be conducted	by	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		STH ST	
WHITE C	OAK HEALTH CAM	IPUS		CELLO, IN 47960	
	T			1	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	,	
		d. She indicated the		DHS or designee weekly on easing the shift x 1 month, then monthly of	
		does not send a report		each shift x 5 months.DHS or	
	back to the fac	cility with the resident.		designee will audit residents	
				receiving prn medications 3	
		cility policy, received as		x's/week x 1 month, then week	•
	current from the	ne Nurse Consultant on		x 5 months to ensure compliar	nce
	12/17/12 at 10	):55 a.m., titled,		with pain management	
	"Guidelines Fo	or Dialysis Provider		guidelines.Audit results will be brought to monthly Quality	
	Communication	on", indicated, "A		Assurance (QA) meetings.	
	reportshall b	e requested from the		Trends will be reviewed by QA	<b>\</b>
	· ·	der that will alert		Committee x 6 months or until	
	_	ding:other information		100% compliance is achieved.	
		ssary for ongoing			
		are. 5. Upon return from			
	•	rovider the campus			
	_	de ongoing monitoring			
	of the shunt si				
		•			
		o. Review the Dialysis			
		rwork for any necessary			
	follow up requ	irements"			
	· ·	olicy from the Dialysis			
	•	ed from the MDS LPN			
		t 11:50 a.m., titled,			
		Catheter: Exit Site			
		ated, "To establish			
	guidelines for	catheter exit site care to			
	reduce the infe	ectious complications			
	associated wit	h intravascular catheter			
	usedressing	changed after each			
	1	treatment and/or if			
		mes damp, soiled or			
		or when inspection of			
	the site is nec	-			
		reatment of exit site			
	iuentineation/t	realinent of exit site	1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155782	B. WIN			12/21/2012
			p. (/1.		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6		
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	changes/inflam	nmation minimizes				
	infectious com	plications and				
	preserves catheter integrity/function"					
	B. A physician	's order, dated				
	12/07/12, indicated to limit the					
	,	s to one liter (1000				
	cubic centimeters) (cc) per day.					
		o. o, (oo, po. da.).				
	The Physician'	s Recapitulation				
	Orders, dated 12/12, indicated the					
	resident received one bottle of Boost					
		ment) (237 cc) daily on				
		inent) (237 cc) daily on				
	day shift.					
	The resident's	fluid intake record the				
	following daily					
	12/08/12-1440					
	12/09/12-1710					
	12/10/12-1380					
	12/11/12-1120					
	12/12/12-1140					
	12/13/12-1230					
	12/14/12-900 d	CC				
	12/15/12-1660	СС				
	12/16/12-1224	CC				
	During an inter	view on 12/17/12 at				
	8:45 a.m., LPN	I #11 indicated the				
		ed 90 cc of fluid with				
		on pass. She indicated				
		d not get medications				
		y give the resident 180				
		-				
	cc's of fluid wit	n the morning				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		(X2) MULTIPLE A. BUILDING	CONSTRUCTION  00	(X3) DATE COMPI 12/21	LETED
		100762	B. WING			72012
NAME OF I	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE S 6TH ST		
WHITE C	OAK HEALTH CAM	PUS		TICELLO, IN 47960		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE )PRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY		DATE
		ss. (360 cc/day with				
	medication par	SS)				
	During an inte	rview on 12/17/12 at				
	_	Dietary Manager (DM)				
		esident received 213				
		She indicated the				
	Registered Die					
	_	are plan on fluid				
		ne indicated the nurse				
	communicated	I the fluid restriction				
	_	ary order form and then				
		information on the				
	1	card. She indicated				
		are the resident				
		t daily. She indicated				
		e Boost had already into the nurses' fluids.				
		the Registered				
		checks the residents				
	, ,	ndicated the last time				
	the Registered					
	_	resident was on				
	11/29/12.					
	_	rview on 12/17/12 at				
		DM indicated the RD				
	was not inform	ned of the fluid				
	restriction.					
	2 During on a	phearyation on 12/14/12				
	_	observation on 12/14/12 PN #4 prepared				
		s medications, which				
		xin (heart medications)				
	250 microgran	,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155782	A. BUII B. WIN			12/21/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8					
WHITE O		au e		814 S 6			
WHITE O	OAK HEALTH CAME	-05		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
TAG	LPN #4 then en room and obtain radial pulse for stated it was, "administered the The resident's Recapitulation indicated and of micrograms, or fibrillation and if the resident's than 50.  During an interestant 2:52 p.m., the limiticated the fapolicy on admining A facility Profestitled, "Nursing indicated, "digo (Lanoxin)ADI e giving drug, the giving drug drug, the giving drug drug drug drug drug drug drug dru	ntered the resident's ined the resident's 15 seconds and 16". (64/min), and ne medications.  Physician's Orders, dated 12/12, order for Lanoxin 250 ne tablet daily for atrial to hold the medication is heart rate was less view on 12/17/12 at Nursing Consultant acility did not have a nistration of Lanoxin.  Sional Resource, Drug Handbook 2012", oxin MINISTRATIONBefor take apical-radial pulse 2's clinical record was 2/17/12 at 11:00 a.m. is diagnoses included		IAU			DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF F	PROVIDER OR SUPPLIEF			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TATALE OF F	NO VIDER OR SUIT LIEF			814 S 6			
WHITE C	OAK HEALTH CAMI	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ent/stroke) with					
	hemiplegia (pa	• .					
	vertebral comp	ression fracture.					
	A care plan init	tiated on 5/16/12 and					
	updated on 8/1	4/12 indicated the					
	resident had a	cute and chronic pain					
	AEB (as evide	nced by) complaints of					
	pain. The inter	rventions indicated to					
	monitor and re	port to nurse signs and					
	symptoms of p	ain, worsening pain,					
	report changes	s in pain location/type					
	frequency/inter	nsity to physician,					
	provide comfoi	rt measures, relaxation					
	techniques, rep	positioning, administer					
	medications, m	nonitor effect and for					
	side effects fro	m routine pain					
		n (as needed) pain					
		nvite, encourage,					
		cort to preferred					
		ultation as needed,					
	·	ent/family about comfort					
		algesic medications,					
		ent physician if the					
		not state/demonstrate					
		ion of pain after one					
	hour or receiving	•					
		ng the mat id make a referral to					
		sician to consider					
	I -	for pain prior to activity					
	to optimize par	ucipation.					
	A Pain Circum	stance, Assessment,					
		and Intervention form					
		at 00:20 a.m. (12 a.m.)					
	dated 9/10/12	at 55.25 a.m. (12 a.m.)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPI 12/21	LETED	
		155762	B. WIN	_		12/21/	72012
NAME OF P	ROVIDER OR SUPPLIER	t .			ADDRESS, CITY, STATE, ZIP CODE		
MUUTE C		21.0		814 S 6			
WHITE C	OAK HEALTH CAME	<sup>2</sup> 08		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated the re	esident had					
	generalized pa	in related to					
	osteoarthritis, \	vertebral compression					
	fracture, and cl	hronic right leg pain.					
	The intensity in	idicated severe pain					
	and the resider	nt experienced pain					
	almost constar	itly in the last 5 days.					
	The assessme	nt indicated the pain					
	limits the reside	ents activities, sleep					
	and sitting. Fa	ctors contributing to					
	pain was thera	py and turning in the					
	bed. Symptom	s/behaviors related to					
	pain was ange	r and combativeness.					
	The assessme	nt stopped on 9/21/12					
	10:00 p.m. to 6	:00 a.m. shift.					
	A care plan init	iated on 6/19/12 for					
		ems, interventions on					
	•	ed to ask the resident if					
	he was in pain						
	appropriately.						
	A quarterly MD	S (Minimum Data Set)					
		ated 9/14/12 indicated					
		as cognitively intact.					
	and redident we	to obginitively intuot.					
	An IDT (Interdi	sciplinary Team) note					
	•	indicated they felt the					
		vior of yelling out was					
	related to pain.	, ,					
	reialeu lo pairi.						
	A CAB (Care A	rea Peview) note					
		Area Review) note indicated the resident					
		physical behaviors but					
	statt indicated	he was "getting a little					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN	IG		12/21/	2012
NAME OF B	ADOLUDED OD GUDDU IED		-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	DROWING BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· -	DATE
	better".						
	9/26/12 Reside	ent First Conference					
	Notes indicated no pain issues.  A Social Service note dated 10/2/12						
	indicated the re	esident became verbal					
	and physical ag	ggressive during ADL					
	care at 2:00 a.ı	m. due to being					
	awakened. Nu	rsing requesting					
	physician for an order of an						
	antidepressant or anti-anxiety						
	medication rou	tinely.					
	Th = 40/0040 4	4/0040 and 40/0040					
	· ·	1/2012, and 12/2012					
	_	apitulation Orders					
		esident was started on					
		cg/hr (microgram per					
	, ,	) patch for chronic pain					
		rlenol 650 mg three					
		s started on 10/3/12.					
		d hydrocodone (pain					
	,	325 mg (milligrams)					
	every four hour	•					
		n 650 mg every four					
		ed for pain was started					
	on 10/3/12.						
	A physician's n	ote dated on 10/3/12					
		esident complained of					
		ncreased Fentanyl					
	patch to 50 mc	•					
	, paton to 00 mo	<b>J</b> ∙					
	A Nurse Practif	tioner's note dated on					
	10/17/12 did no	ot indicate a follow up					

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				6TH ST	
WHITE C	OAK HEALTH CAME	708 	MONT	ICELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	of pain.				
	The October M	La mattala e Nile emaion as			
	The October Monthly Nursing Assessment did not indicate an assessment of the pain section.				
	The DDN /cc =	readed) MAD			
	The PRN (as needed) MAR (Medication Administration Record)				
	,	•			
		l hydrocodone was 12 at 11:50 p.m.,			
	_	-			
	11/8/12 at 4:40 p.m., 11/11/12 at 12:05 p.m., 11/16/12 at 5:25 p.m.,				
	•	35 p.m., 11/20/12 "x 1",			
		11/28/12 "x 2",			
	•	The narcotic sheet			
		esident received 15			
		codone versus the 10			
	,	e medication record.			
	indicated on th	c medication record.			
	The PRN MAR	sheet indicated			
		vas given on 12/3/12 at			
	-	1/12 at 2:45 a.m.,			
	,	specific time, 12/8/12			
		2/10/12 at 3:45 a.m.,			
		no specific time,			
	12/13/12 "x 2".	-			
	The PRN medi	cation tracking sheet			
		ocodone was given on			
	•	5 a.m., 12/5/12 at 2:10			
		at 4:45 p.m., 12/7/12			
		c time, 12/8/12 at 3:45			
	· •	at 3:45 a.m., 12/13/12			
		nd 12/13/12 at 5:20			
	a.m.				
1			1	1	

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
			1				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		IAG	DEFICIENC!)		DATE
TAG	The narcotic sh to 12/10/12 ind received 9 dos versus the 5 do medication recindicated on the tracking sheet.  A Monthly Nurs 11/8/12 indicate the resident recident recident regimen. The pain was frequenced moderate pain. The pain had ling the resident has complaints pain over". There we done for the medications are gimen. The pain had linguished the resident has complaints pain over". There we done for the medications are gimen. The resident has at 12:30 p.m., the staff "hurt him wand clean him."  A Nursing Note at 2:00 p.m., the staff "hurt him wand clean him."	sing Assessment dated ed in the last 5 days, ceived prn pain and scheduled pain assessment indicated ent and he had with facial grimacing. mited daily activities. and vocalized in to his back, "legs, all was no assessment onth of December.  The indicated on 11/10/12 the resident hit staff he nurse spoke to the e had indicated the when they roll him over		TAG	DEFICIENCY)		DATE
	interiorly, and t	The foot was red he resident pain. The narcotic					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUI	LDING	NSTRUCTION 00		E SURVEY LETED 1/2012	
		100702	B. WIN		ADDRESS, CITY, STATE, ZIP COI		
NAME OF F	PROVIDER OR SUPPLIER			814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	sheet was obsewas given for the this time. The Tylenol was obgiven at 3:00 p. A physician nor not indicate a few short at 12/11/12 at 3:3 "hurts all over a wants to stay in alone".  An observation a.m. in the dinicomplained of chair to RA (resident was in on a shoe but a nursing assistate resident she had closet and he work to stay in a sitting on a resident was not repositioned in the short to the resident was not repositioned in the short to the short to the resident was not repositioned in the short to t	erved and no vicoding the resident's pain at scheduled 650 mg of served on the MAR as a.m.  The dated on 12/5/12 didentificated he all the time and just in bed and be left  on 12/13/12 at 9:00 mg room, the resident discomfort in his wheel storative aide) #6. The sisting he was sitting a CNA (certified int) indicated to the ad put his shoes in his was sitting on a gelesident indicated he comething hard. The ot checked or his wheel chair.				ROPRIATE	
	and ADON (As Nursing) on 12 The SSD indica the resident's p	al Service Director) sisted Director of /18/12 at 10:00 a.m. ated she was aware of vain and has been e staff. The SSD was					

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If continuation sheet

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	OF CORRECTION  OF CORRECTION  155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/21/2012			
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS	814 S 6	STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				
	not able to indicate how she was working with staff and indicated she receives her information from staff notes or behavior sheets. The ADON indicated there were pain assessment sheets the staff can fill out to document the resident's pain. The ADON was not aware of the staff not following up with the physician for the resident's continued pain despite the increase in the Fentanyl patch in September and was not aware the pain assessment had not been documented and pain scales were not used on the prn medication sheets.  A Guideline for Pain Assessment and Management was provided by the Administrator on 12/18/12 at 3:00 p.m. The guidelines indicated "Ongoing assessment will be documented on the Monthly Nursing Summary, and Skilled Nursing Assessment form if applicableIf there is a change in pain indicators or verbalizations from resident, a pain circumstance form will be completed to indicate changes and care plan updateAssess for behaviors that may be indicators of pain or activities that increase indicators of pain.  3.1-37(a)						

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	te survey Pleted 21/2012		
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST					
WHITE C	OAK HEALTH CAMI	PUS	MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155782  NAME OF PROVIDER OR SUPPLIER  WHITE OAK HEALTH CAMPUS  IDENTIFICATION NUMBER: A. BUILDING B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 814 S 6TH ST MONTICELLO, IN 47960	
155782  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST	(X5)
NAME OF PROVIDER OR SUPPLIER  814 S 6TH ST	(X5)
	(X5)
WHITE OAK HEALTH CAWIFUS	(X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
F0312 SS=D ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview and record review, the facility failed to ensure a resident's teeth were clean for 1 of 2 residents reviewed for ADL (activities of daily living) assistance. (Resident #56)  Findings include:  An interview with a family member on 12/12/2012 at 10:14 a.m., indicated Resident #56 does not receive the assistance she needs with routine oral hygiene. The family member indicated the staff was bad about the resident's teeth and hair.  On 12/13/12 at 8:20 a.m., the resident was observed in the hallway near the unit lounge with her hair combed and was walking with restorative therapy to dining room for breakfast. Prior to eating breakfast, the resident's teeth were observed in conversation at the breakfast table, and were observed to have had a white substance in between her teeth near the gum line. Interview with the	01/20/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUI	LDING	NSTRUCTION 00		ESURVEY LETED /2012	
	PROVIDER OR SUPPLIER		B. WIN	STREET A 814 S 6	ADDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN 47960	<b>I</b>	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	Student Nurses indicated she h	s' Aide during this time ad cleaned the when she had gotten					
	on 12/13/12 at #56's diagnose not limited to, o	record was reviewed 8:45 a.m. Resident is included but were dementia, anemia, and demia's (irregular heart					
	Set) Assessmentindicated the recognitively impreceived an as	MDS (Minimum Data ent dated 10/1/12 esident was severely aired and the resident sistance of 1-2 staff ressing and personal					
	indicated the re (activities of da deficit of dressi hygiene and ba weakness. The included, asses status changes changes in AD and responsible personal hygie oral/dental care	esident had an ADL ily living) self care ng, toilet use, personal athing related to e interventions es/record self care f, report significant L status to physician e party, assist with ne as needed including e, assist of 1, and romote hygiene and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
		155782	B. WING		12/21/2012			
NAME OF D	DOMDED OD GUDDI ICI		STREET	ADDRESS, CITY, STATE, ZIP CODE	•			
NAME OF P	ROVIDER OR SUPPLIEI	Λ	814 S	814 S 6TH ST				
WHITE C	OAK HEALTH CAM	PUS	MONTICELLO, IN 47960					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
	On 12/13/12 a	t 10:00 a.m., Resident						
	#56 observed	to have a white						
	substance in b	etween her teeth and						
	near the gum I	ine.						
		rith a family member on						
		30 p.m. indicated 6						
		ad been put in the						
		ture cup a few days ago						
		the denture tabs had						
	been used.							
	│ │	t 3:15 p.m., 6 denture						
		rved in the denture						
	cup.	ived in the dentare						
	cup.							
	3.1-38(a)(3)(C	)						
	3.1-38(b)(1)	,						
	30(0)(1)							

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315 SS=D	BLADDER Based on the res assessment, the	PREVENT UTI, RESTORE ident's comprehensive facility must ensure that a ers the facility without an					
	indwelling cathete the resident's clin that catheterization resident who is in receives appropri to prevent urinary restore as much a possible.	er is not catheterized unless ical condition demonstrates on was necessary; and a continent of bladder ate treatment and services a tract infections and to normal bladder function as	F022	15			01/20/2012
	a resident rece assessments, to restore as m function as pos- resident who w declined to fred urine for 1 of 1 urinary incontin Findings includ Resident #35's on 12/17/12 at resident's diagration were not limited dementia.  The Admission (MDS) Assession	acility failed to ensure ived appropriate reatment, and services uch normal bladder sible, related to a ras continent of urine quently incontinent of resident reviewed for nency. (Resident #35)	F03	15	1. Resident #35 has had no adverse affects related to alleg deficient practice. Residents with changes in urinary incontinence have the potential being at risk of alleged deficier practice. Any residents who experienced a change in incontinence based on Minimus Data Set Assessments (MDS's) and feedback from nursing staff within the last 30 days will have documentation reviewed to ensure an assessment was completed. If assessment is not documented one will be completed. 3. Nurs staff including Minimum Data Set Assessment Coordinator (MDS will be in-serviced on necessal assessment documentation with changes in urinary incontinence Certified Resident Caregiver Associates (CRCA's) will communicate increased episor of incontinence to the nurse with will initiate an Elimination Circumstance Form. If necessions in the process of the continuation of the continuation of the continuation.	al of nt  an d, ing Set SC) ry th se.  des ho	01/20/2013

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155782	B. WIN			12/21/2012	
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE	OAK HEALTH CAMI	DITE			CELLO, IN 47960		
				WONT	CELEO, IN 47 900		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A care plan, dathe resident was and bladder. To related to incorrect and dry". The "Complete bown assessment at and PRN (as not incontinence of incontinence after meals, upbefore bed at recompleted with Change MDS at the reason for of incontinency, at toileting scheduler.	ated 10/22/12, esident was frequently urine.  ated 11/07/12, indicated as incontinent of bowel The goals indicated, of skin breakdown interventions included, wel and bladder admission, quarterly seeded), Provide are after each episode eToilet before and inght"  ack of documentation to sessment had been in the Significant Assessment to indicate the incontinency, type of and for a personal			a 72 hour Elimination Record/Schedule will also be inititated to determine patterns incontinency and if a toileting schedule will prevent incontinency.4. DHS or designee will ensure any residents experiencing change in urinary incontinence have a Elimination Circumstance Forr completed with each change identified. This will be done 5 x's/week x 1 month, then 3x's/week x 1 month, then wex x 4months. Audit results will be brought to monthly Quarterly Assurance (QA) meetings. Trends will be reviewed by QA Committee x 6 months or until 100% compliance is achieved.	es n n ekly e	
	11:50 a.m., the Significant Cha had been comp	view on 12/17/12 at e MDS LPN indicated a ange MDS Assessment pleted because the fall and had declined					

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155782	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	E SURVEY PLETED 11/2012		
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	and that was when the incontinency started.						
	3.1-41(a)(2)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155782	B. WIN			12/21/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
WHITE C	OAK HEALTH CAME	PUS	814 S 6TH ST MONTICELLO, IN 47960				
					T		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323	483.25(h) FREE OF ACCID	ENT					
SS=E		RVISION/DEVICES					
		ensure that the resident					
	_	ains as free of accident					
		sible; and each resident					
	•	e supervision and					
		es to prevent accidents.					
	A. Based on o	bservation, interview	F03	23	1. Residents #29, #28, #29, #5	55,	01/20/2013
		ew, the facility failed to			#57, #67 and #97 had no adve	erse	
		ations were not left on			affects noted related to alleged		
		cation cart for 1 of 11			deficient practice. Resident #1		
	•	rved for medication			had no adverse affects noted		
					related to alleged deficient		
		failed to ensure staff			practice. There were no adver- affects noted related to alleged		
		of 3 units unattended,			deficient practice regarding wa		
	and failed ensu				temperatures. Resident #13 ha		
	_	ater temperatures for			no adverse affects noted to		
	3 of 3 units. (2	00 Unit, Residents			alleged deficient practice.		
	#25, #28, #29,	#55 #57, #67, and			Resident #46 has had care pla		
	#97, LPN #4, R	RN #13, and CNA #14)			interventions updated to reflec	t a	
		·			2 person		
	B. Based on o	bservation, interview			transfer.2.Residents with	riale	
		iew, the facility failed to			alarms have potential to be at for alleged deficient practice.	IISK	
		arm was secured as			Nurses will be in-serviced to		
					remain on unit when all Certific	ed	
		acturing instructions,			Resident Caregiver Assistants		
		nsure a resident was			(CRCAs) go off unit.Residents		
		ely as ordered for 2			receiving medications have		
		wed for accidents and			potential to be at risk for allege	ed :	
	supervision. (F	Resident #13 and #46)			deficient practice. Licensed		
					Nurses will be in-serviced on r		
	Findings includ	e:			leaving medications on top of tomedication cart. A new mixing		
	<b>.</b>				valve was installed on 1/8/13 t		
	A1. On 12/14/	12, Resident #57's call			ensure consistent water		
		ved to have been			temperatures within the		
		8:30 a.m. to 8:42 a.m.			acceptable range. Director of		
	going on nome	5.50 a.III. 10 0.42 a.III.			Plant Operations (DPO) now		
					takes temperatures on every u	nit	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAMI	DITE					
WHITE	AK HEALTH CAIVII	-03		MONTICELLO, IN 47960			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Resident #67's	call light was			5 x's/week. Nursing staff will b	е	
	observed to be	going off from 8:32			in-serviced on appropriate		
		m. Resident #67 was			placement of the call lights wit		
		' several times for			resident reach and compliance		
	assistance.				with bed alarms being secured and in use as indicated.	ג	
	assistance.				Licensed nurses and Qualified	I	
	The	atoff aban werd to the			Medication Aides (QMAs) will		
		staff observed in the			in-serviced to document on the		
		:32 to 8:39 a.m.			Medication Administration		
		, #28, #29, #55, #57,			Records (MARs) when batterie	es	
	#67, and #97 v	vere left unattended on			are changed on alarms as		
	the floor.				indicated. Positioning and		
					functioning of alarms will be		
	CNA #14 had	walked a resident to			added to MARs of those reside	ents	
		n and the LPN #4 was			who have alarms for	4-	
	_				licensed nurses and/or QMAs check and document every sh		
	in the dining ro	orn passing			Nursing staff will be informed of		
	medications.				requirement of 2 person transf		
					for Resident #46.3. Director of		
	At 8:40 a.m., F	Resident #57 was			Health Services (DHS) or		
	observed walk	ing back to her chair			designee will conduct random		
	next to her bed	and had indicated she			rounds on units on various sh	ifts	
	went to the bat	throom by herself.			to ensure staff is present wher	า	
					resident(s) with alarms are		
	Interview with t	the CNA #14 on			present on the unit 5x's/week		
		50 a.m. indicated a			month, 3x's/week x 1 month, the	nen	
					weekly x 4 months. DHS will conduct random rounds on		
		ave stayed on the unit			various shifts on various units	to	
	during the mea	al time.			ensure medications are not lef		
					on top of the medication carts	-	
	Resident #67's	s clinical record was			5x's/week x 1 month, 3x's/wee	k x	
	reviewed on 12	2/13/12 at 2:49 p.m.			1 month, then weekly x 4 mon		
	Resident #67's	diagnoses included			Executive Director or designed		
	but were not lir	•			will review water temperatures		
		gular heart beat),			5x's/ week x 6 months to ensu	re	
	,	COPD, and dementia.			water temperatures are at		
	119pc11c11510f1,	OOI D, and demendia.			appropriate temperature and	on	
					temperatures are being taken every unit.Director of Health	UII	
	Resident #67's	Monthly Nursing			CVCTY GITTLE DITECTOR OF FIEARLIT		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155782	A. BUIL			12/21/	/2012
			B. WINC		DDDFGG CITY CTATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CODE		
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		ADU O		814 S 6			
WHILE	DAK HEALTH CAN	IPUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Assessment of	lated 11/9/12, the safety			Services or designee will cond	luct	
	section indica	ted the resident has			random rounds to ensure call		
	cognitive impa	airment that effects			lights are within reach and ala	rms	
		ent, had a history of falls,			are in proper place and	-41-	
		tance for transfers and			functioning 5 x's/week x 1 mor 3x's/week x 1 month, then wee		
	•				x 4 months. Medical Records	•	
	·	oliant with safety			designee will audit MARs to		
	measures.				ensure licensed staff compliar	ice	
					with positioning, functioning ar	nd	
		s clinical record was			battery replacement of alarms	5	
	reviewed on 1	2/17/12 AT 2:00 p.m.			x's/week x 1 month, then		
	Resident #57'	s diagnoses included			3x's/week x 1 month, then wee	•	
	but were not I	imited to Parkinson's			x 4 months. DHS or designee conduct random rounds during		
	Disease, CAD	(coronary artery			transfers of Resident #46 to	9	
	disease), ane	mia and arthritis.			ensure staff is compliant with	2	
	,,				person transfers 3x/'s week x		
	A care plan da	ated 9/18/12 indicated			month, then weekly x 5 month		
	•	ad a fracture related to			4.Audit results will be brought	to	
					monthly Quality Assurance (Q		
		plan dated 9/18/12			meetings. Trends will be revie		
		resident had an			by QA Committee x 6 months	or	
	1	ral nervous system			until 100% compliance is achieved.		
	related to Par	kinson's Disease.			acilieved.		
	A daily report	sheet received from the					
	Assistant Dire	ctor of Nursing on					
	12/14/12 at 10	0:15 a.m. indicated 3 of					
	the 7 resident	s left unsupervised on					
		alarms related to having					
		lls or identified as a fall					
	•	s #29, #67, and #97.					
	TISK (IXESIUEIII	3 π∠3, #U1, allu #31.					
	A	a abaamiatian asa					
	_	n observation on					
		47 a.m., RN #13					
	prepared Res	ident #1's medication,					
	which consiste	ed of Allopurinol (gout					
		esnirin lexanro					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLE	TED
		155782	B. WIN			12/21/2	012
			D. 111		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		nt), Metoprolol (blood menda (dementia), and					
	Risperidone (a	· ·					
	RN #13 then c	rushed the medications					
	and placed the	•					
		o. RN #13 then					
	measured out	a cap full of Miralax					
	(laxative) and i	mixed the Miralax with					
	a half glass of	water.					
	RN #13 then w	alked from the					
		in the hall outside of					
		room, walked into the					
		room to wash her					
		the medications on top					
	of the medicati	ion cart. The					
	medication car	t was not in view of					
	RN #13.						
	A3. During an	observation with the					
		Director, on 12/13/12 at					
		temperature of the sink					
		athroom, also used by					
	'	of the facility, was					
		p.m. the water					
		resident room 306 was					
	122.7.	Tesident room 500 was					
	122.1.						
	During an inter	view at the time of the					
	1	e Maintenance Director					
		as unsure when the					
		ometer had been					
		indicated he took					
	water tempera	tures every morning.					

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Event ID: KGNH11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CO	NSTRUCTION	l í	ATE SURVEY MPLETED	
ANDILAN	of connection	155782	A. BUIL		00		21/2012
		.537.02	B. WING		DDDECC CITY OT THE CITY OF		
NAME OF I	PROVIDER OR SUPPLIEF	₹		814 S 6	DDRESS, CITY, STATE, ZIP C	ODE	
WHITE (	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
							(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
IAU	A Plant Operative received from the 12/14/12 at 11 Maintenance Excheck list, which temperature chrooms.  The Daily Temperature chrooms.  The Daily Temperatures. The Daily Temperatures. The Poily Temperatures. The Daily Temperatures are the Daily Temperatures and the Daily Temperatures are the Daily Temperatures. The Daily Temperature are the Daily Temperatures are the Daily T	tional Overview, the Administrator on 245 a.m., indicated the Director had a daily th included water necks in the residents'  perature Logs, dated 12, indicated only one cked daily for water The form indicated the was either a resident 2', a shower room, a an area in the facility's		IAG			DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN			12/21/	2012
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAM	פווכ		814 S 6	TH ST CELLO, IN 47960		
			1		OLLEO, IIV 47 300		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		ved in bed with no					
		d on the bed. The call					
		rved to be caught					
		ed rail and the table					
	hanging down	near the floor. The					
	DON was brou	ght back into the room					
	at 10:25 a.m.,	where a pull tab alarm					
	was observed	lying on the bed					
	unsecured and	I clipped onto resident					
	shirt. The call	light was still out of the					
	_	p. Interview with the					
	_	e time indicated "it					
	•	n the alarm should be					
		bed. The DON was					
		looking around the					
	•	d alarm, and did not					
		light until it was brought  . The DON moved tab					
		way from resident,					
		bed, and indicated					
		vere easy to trigger.					
	The contract of the contract o	vere easy to trigger.					
	Resident #13's	clinical record was					
		2/13/12 at 10:16 a.m.					
	Resident's #13	s's diagnoses included					
		mited to, dementia with					
	behaviors, hyp	ertension, and chronic					
	renal insufficie						
		Recapitulation orders					
		licated that on 6/12/12,					
		vas to be placed while					
		as in wheel chair and					
		Staff was to check					
	positioning and	d functioning of monitor					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE		DATE
1110		*		0			5.112
	1	aff was also to change					
		the alarms every					
	month. The No						
	December MAI	•					
		Record) did not					
		oatteries were changed					
	and there was	incomplete					
	documentation	for all shifts for					
	checking tab a	larm.					
	A care plans w	as initiated on 6/25/12					
		n 9/23/12 for the					
	•	history of falls. The					
		idicated to "call light					
		_					
		12/12 [sic] tab alarm to					
		d bed and on 11/17/12,					
	staff was educa	ated on the alarm.					
	An interview w						
	_	44 a.m. indicated the					
	resident had fa	llen within the last 30					
	days but was u	insure if there was any					
	injuries.						
	A manufacturin	ng recommendation					
	brochure was p	provided by the DON					
		4:00 p.m. The					
		ons indicated to					
	"attach the A						
		air or bed using the					
		al Universal Mounting					
		•					
	· ·	the alligator clip to the					
	_	nentThis product is					
	not designed to	•					
	patient'sand	should not be used as					

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012
(X5) COMPLETION DATE

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
		1		ADDRESS, CITY, STATE, ZIP	. CODE
NAME OF I	PROVIDER OR SUPPLII	ER	814 S 6		
WHITE C	DAK HEALTH CAN	MPUS		CELLO, IN 47960	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	· 1	(Y5)
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	
TAG	`	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THI DEFICIENCY)	
		transfer to the wheelchair			
		dn't want to wait."			
	but, resident did	ant want to wait.			
	On 10/11/10 at 3	.05 D.M. DN #0 was			
		:05 P.M., RN #9 was			
		indicated during the 12/9/12			
		6 was being assisted by two			
		the restroom until one left to			
	1	e bag. RN #9 indicated			
	Resident #46 did	not want to wait for the			
	second staff to re	eturn to transfer to his			
	wheelchair which	led to the fall incident. RN			
	#9 stated it wasn	't uncommon for Resident			
	#46 to be left with	h one staff if he wasn't ready			
		n asked whether RN #9			
		s aware the care plan			
		ident required two staff to			
		stated the fall would have			
		avoidable had the required 2			
		een in attendance with			
	Resident #46.				
	3.1-45(a)(1)				
	3.1-45(a)(2)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) N			ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
			_				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ſΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0325	483.25(i)	NITION OTATIO ( IN 11 500					
SS=D		RITION STATUS UNLESS					
	UNAVOIDABLE	antla comprehensive					
		ent's comprehensive facility must ensure that a					
	resident -	idenity must ensure that a					
		eptable parameters of					
		such as body weight and					
		less the resident's clinical					
		strates that this is not					
	possible; and						
		erapeutic diet when there is					
	a nutritional probl						
		ervation, interview and	F03	25	1. Resident #67 no longer resi	des	01/20/2013
	record review,	the facility failed to			at the facility.2. Residents		
	implement app	roaches to ensure a			identified at risk for weight loss		
	resident mainta	ained a usual body			have the potential to be at risk alleged deficient practice. Curr		
	weight in 1 of 6	residents reviewed for			residents identified at risk for	CIII	
	weight loss and				weight loss will be reviewed fo	r	
	supplements. (	•			appropriate approaches for		
	ouppiemento. (	resident nor )			ensuring a usual body weight i	s	
	Findings includ	lo:			maintained, interventions are		
	i indings includ	ic.			added accordingly and		
	4 5 11 1/10	<b>&gt;</b> →1 1: · · 1			Registered Dietician (RD) is	ا	
		37's clinical record was			notified of weight loss per facil		
		2/13/12 at 2:49 p.m.			guidelines.3. Assistant Directo Health Services (ADHS) is	ı OI	
	Resident #67's	diagnoses included			responsible for weight tracking	 	
	but were not lin	nited to, atrial			and will be in-serviced on High		
	fibrillation (irreg	gular heart beat),			Risk Nutrition Guidelines and		
	hypertension, (	COPD, and dementia.			Guidelines for Weight Tracking	ا.	
	, , , , , , , , , , , , , , , , , , ,	•			These guidelines include		
	A care plan wa	s initiated on 12/22/11			documentation guidelines and		
	•	on 09/13/12, indicated			when to communicate with the		
		as a nutrition risk. The			RD.4. Director of Health Service	es	
					(DHS) or designee will audit residents with weight loss wee	klv	
		ndicated to monitor and			x 6 months per Guidelines to	му	
		nysician signs and			ensure RD has been notified a	ınd	
	• •	nalnutrition, significant			that approaches and interventi		
	weight loss, ch	ewing/swallowing			have been initiated accordingly		
			1		İ		1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/2012	
			Б. WH		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	3		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
			-1				(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	``	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		<u> </u>		IAG	Audit results will be brought to		DATE
1	l •	ninister nutritional			monthly Quality Assurance (Q		
1	support as ord	•			meetings. Trends will be revie		
	1	provide/monitor intake			by QA Committee x 6 months		
		eigh and monitor			until 100% compliance is		
	results monthly	y and prn.			achieved.		
	A Nutrition Ass	sessment and Data					
	Collection was	completed on 6/15/12.					
	The assessme	nt indicated the					
	resident's usua	al body weight was 132					
		and her BMI (Basal					
		ex) at that time was 21.2					
	which was slig	•					
		22. Resident #67's					
		ped to 19.9 on 12/2/12.					
	Bivii Hau uropp	Jed to 19.9 of 12/2/12.					
	On 6/21/12 th	a IDT (Interdisciplinary					
		e IDT (Interdisciplinary					
	l '	n/Hydration Plan of					
		ited on AEB (as					
		decreased skin					
		target goal date was					
		nterventions indicated					
	to give diet as	ordered by the					
	physician, hon	or resident					
	preferences, o	ffer snacks prn, monitor					
	skin integrity vi	ia supportive					
		; medications as					
		physician, monitor					
		nges every month and					
	•	D (Registered Dietician)					
	•	v in CAR (Care Area					
	l • ·	v III OAIX (Oale Alea					
	Review) prn.						
	A Diotominaria	rose note on 0/42/42					
	, , ,	ress note on 9/13/12					
	indicated the re	esident's weight was					

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	of Correction X1) Provider/Supplier/Clia identification number:  155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS	814 S 6	ADDRESS, CITY, STATE, ZIP CODE TH ST CELLO, IN 47960	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	128.8, been stable at 130+/- few pounds. There was no significant change in weight. The resident ate an average of 92.3% at meals and 100% bedtime snack. The resident received cottage cheese or yogurt three times a day between and with meals. The yogurt and the cottage cheese was discontinued due to a wound had healed. The labs from 9/10/12 reviewed. The Plan of Care was updated. There were no new interventions and to follow protocol as needed.  A Hepatic Function blood test was done on 12/10/12 which indicated the resident's Albumin was 3.1 L (3.5-5.0). (Low can be an indicator for malnutrition)  The resident's weight for the last 6 months are as follows: 6/15/12: 124.4 6/19/12: 131.6 7/6/12: 130.2 8/6/12: 133.0 9/8/12: 128.8 10/5/12: 128.8 10/5/12: 120.8 11/6/12: 127.4 12/2/12: 123.0  A fax dated 12/11/12, to the physician, indicated the resident had lost 5% of weight in the past two			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN	G		12/21/	2012
NAME OF F	PROVIDER OR SUPPLIEI	3	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				814 S 6			
WHITE C	OAK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	MARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CO		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		ad gained since					
	admission and was currently back to admission weight".						
		rd dated 10/14/12 to					
	· · · · · · · · · · · · · · · · · · ·	cated the resident had					
		75% of 44 meals					
		fast, lunch, and dinner that were not indicated					
		ate the meal or refused					
		re were 45 days that a					
		indicated if given or					
	accepted and	eaten.					
	An intonvious w	rith the DM (Dietary					
		2/18/12 at 9:00 a.m.,					
		does not manage the					
		residents and the					
		ages the weight losses					
		recommendations.					
		recommendations.					
	An interview w	rith the ADON on					
		:30 a.m., indicated the					
		nanage the residents					
		there was a weight					
	_	ON indicated she had					
		ysician, family, and					
	•	he weight loss and					
	_	new orders. The					
		ed the Dietician had not					
		ilding this week to					
	document.	nang tino week to					
	document.						
	An interview w	rith the Administrator					
		2/19/12 at 4:40 p.m.,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
		1		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R	814 S 6		
WHITE C	OAK HEALTH CAM	PUS		CELLO, IN 47960	
				1	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		ADON was responsible			
	_	weights and the			
	procedure for i	notification was to			
	document find	ings in a book/binder			
	for the dieticia	n to review, if she			
	would recomm	end a supplement, the			
		family would be notified			
	of the recomm	•			
		visits the facility once a			
		vas no system in place			
		and making sure the			
		aware of the weight			
		dministrator indicated			
		should have been			
		esident's usual body			
	_	ninded of abnormal			
		e passes and the			
		nay correlate with a			
	change in con	dition.			
	There has bee	n no documentation by			
		if the dietician was			
	_	e weight loss and there			
	has been no				
		n/assessment by the			
		ating the weight loss.			
		anny the weight 1055.			
	2.1.46(5)(1)				
	3.1-46(a)(1)				
			1		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
	PROVIDER OR SUPPLIEF		814 S 6	ADDRESS, CITY, STATE, ZIP CODE BTH ST CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	AND OVER THE REAL PROPERTY OF A CONTROL OF THE PROPERTY OF THE	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0328 SS=D	The facility must receive proper tre following special Injections; Parenteral and et Colostomy, urete Tracheostomy carriacheal suctioni Respiratory care; Foot care; and Prostheses.  Based on obserecord review, assess the respiration machine for 1 of for self medical (Resident #67).  Findings included 1. Resident #67 shout were not limited fibrillation (irregulation). On 12/13/12 at was observed #67's nebulized and left the rock was running and treatment massive colosterial and self-the rock was running and self-the rock was running and treatment massive colosterial and self-the rock was running and self-the r	nteral fluids; rostomy, or ileostomy care; are; ang; ervation, interview and the facility failed to ident for self of the nebulizer of 1 residents reviewed tion administration.  de: 67's clinical record was 2/13/12 at 2:49 p.m. 6 diagnoses included	F0328	1.Resident #67 no longer resident facility.2.Residents receiving respiratory medications have potential to be at risk of allege deficient practice. Incorrect powsa provided to state survey team during the time of the survey. Residents receiving respiratory medications will be assessed for self medication administration. Any changes who be documented and implement accordingly.3. Licensed nurse will be in-serviced on the Respiratory/Inhalation Treamed Guidelines which is the current policy the facility follows. It indicates that "if a resident is stable receiving the treatment nurse does not need to remain the room during the entire administration of treatment". Director of Health Services (Dor designee will conduct respiratory treatment observations on various shifts x's/week x 1 month, weekly x month and monthly x 4 month Audit results will be brought to	g d d dicy  vill nted s ent t t HS)  3 1 s.4.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155782	A. BUILDING B. WING		12/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	ER		6TH ST	
   WHITE C	OAK HEALTH CAM	ADLIS		ICELLO, IN 47960	
WITTE	DARTIEALTIT CAIV		IVIONI	TCELEO, IN 47 900	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	medication an	nd left the room again.		monthly Quality Assurance (C	
	LPN #3 went	into two other resident's		meetings. Trends will be review	<b>I</b>
	room for asse	ssment and medication		by QA Committee x 6 months until 100% compliance is	or
	administration	before returning to		achieved.	
		room and indicated to		deriio vod.	
		ninutes" and she will be			
	back.				
	Daok.				
	I DNI #2 bod n	ot assessed the			
	resident during the nebulizer				
	treatment.				
		at 9:49 a.m., LPN #4			
	was observed	l initiating Resident			
	#67's nebulize	er treatment and left			
	room while ma	achine was running. At			
	9:54 a.m., Re	sident #67 was			
		e coughing hard while			
		treatment mask was on			
	_	I #4 was observed			
	_	e room after 10:00 a.m.			
	_	off the nebulizer			
	machine.				
	LPN #4 had n	ot assessed the			
	resident durin	g the nebulizer			
	treatment.				
	A Specific Me	dication Administration			
	·	olicy dated 2/1/10 was			
		ne Consultant on			
	1 '	0:50 a.m. The			
		dicated this was the only			
		uld find regarding			
	nebulizer's. T	he policy indicated			

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PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUILDING 00 COM				MPLETED 21/2012		
	PROVIDER OR SUPPLIER	us	STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	treatment unles been assessed self-administer, minutes after tr sooner if clinica obtain the resid							

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155782				12/21/2012	
			B. WIN		ADDRESS SITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
VAULUTE O		21.0		814 S 6			
WHITE	OAK HEALTH CAMP	708		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0332	483.25(m)(1)						
SS=D	FREE OF MEDIC	CATION ERROR RATES					
	OF 5% OR MORI	E					
		ensure that it is free of					
	medication error i	rates of five percent or					
	greater.						
	Based on obse	rvation, record review,	F03	32	1. For Residents #1and #25,		01/20/2013
	and interview, t	the facility failed to			nurse will be re-educated on		
	ensure that it w	as free of a			alleged deficient practice relate		
	medication erro	or rate of 5% or			to medication errors. No adver		
					affects were noted.2. Resident	is	
	greater, related to 3 medication errors out of 50 opportunities for error,				receiving medications from		
					nursing staff have potential of being at risk of alleged deficier	. t	
	•	% error rate. This			practice. Medication times will		
	affected 2 of 17	1 residents observed			reviewed to ensure compliance		
	for medication	pass. (Residents #1			with those requiring specific tir		
	and #25)				per pharmacy recommendation		
	,				Medication carts will be audite		
	Findings includ	e.			ensure appropriate cups are		
	i ilidiliga ilicidd	C.			available in order to accomoda	ate	
					the amount of liquid as written	per	
	1. During a me	•			the order.3. Nurses and Qualif	ied	
	observation on	12/13/12 at 7:47 a.m.,			Medication Aides (QMAs) will	be	
	RN #13 prepar	ed Resident #1's			in-serviced on following		
	morning medic	ation, which included			physician's orders and providir		
	_	r (laxative) 17 grams			medications at correct delivery		
	(one lid full).	( ( grains			times as indicated. Nurses and	<sup>1</sup>	
	(One ha fail).				QMAs will have medication		
	DN #40	La applied of the DAN-Land			observations conducted	,	
	•	d a capful of the Miralax			throughout their employment r less than annually and as	iO	
		o and mixed it with 1/2			needed. Medication pass audi	ts	
	glass of water.	RN #13 then entered			will be conducted by Director of		
	the resident's r	oom and administered			Health Services (DHS) or		
	the medications	S.			designee weekly on each shift	x 1	
					month, then monthly each shif		
	During an inter	view directly after the			5 months.4. Audit results will b		
	•	•			brought to monthly Quality		
		of the medications, RN			Assurance (QA) meetings.		
		he glass with the			Trends will be reviewed by QA		
	Miralax held 12	20 cc's (cubic			Committee x 6 months or until		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріп	LDING	00	COMPLETED
		155782	A. BUI B. WIN			12/21/2012
			B. WII		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	R		814 S 6		
WHITE C	OAK HEALTH CAME				CELLO, IN 47960	
	ARTICALITIOAM			WONTE	3EEE3, IN 47300	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	TE COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE
	, ,	lounces). She			100% compliance is achieved.	
	indicated she g	gave four ounces of				
	water with the	Miralax. She indicated				
	she should have used an eight ounce cup.					
	·					
	Review of the i	resident's Physician's				
		Orders, dated 12/12,				
	•	10 a.m., the orders				
		· · · · · · · · · · · · · · · · · · ·				
	indicated, to give Miralax powder 17 grams in eight ounces of liquid.					
	0 5 :	1 1 1 10/40/40				
	_	bservation on 12/13/12				
	· ·	N #13 prepared				
	Resident #25's	medication. RN #13				
	placed the follo	owing medications in				
	plastic medicat	tion cup:				
	Macrobid (antil	biotic) 100 mg				
	(milligrams)					
	omeprazole (st	tomach medication) 20				
	mg	,				
	multivitamin					
	Oyst-Cal 500+	D 200 IU				
	aspirin 81 mg					
	ferrous sulfate	(iron) 325 mg				
	hydrocodone 5	rozo mg (pam				
	medicine)	0.40				
	,	pressant) 10 mg				
		dministered the				
	resident's med	ications to the resident.				
	During an inter	view after the				
	medications ha	ad been given, RN #13				
		esident had just come				
	back to her roc	-				
			1			1

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Event ID: KGNH11

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	OF CORRECTION  OF CORRECTION  155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COI	TE SURVEY MPLETED 21/2012	
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	breakfast. She indicated she was finished with the resident's morning medications.					
	The resident's Physician's Recapitulation Orders, dated 12/12, were reviewed on 12/13/12 at 8:30 a.m. The orders indicated an order for Methenamine Hippurate (reduces the development of drug-resistant bacteria) 1 gm (gram) before meals.					
	During an interview at the time of the review, RN #13 indicated she had not given the Methenamine.					
	A facility Professional Resource, titled, "Nursing Drug Handbook 2012", indicated, "omeprazoleGive at least 1 hour before meals"					
	A facility policy, dated 2/10, titled, "Medication Administration-General Guidelines", received as current from the Nurse Consultant, indicated, "Medications are administered in accordance with written orders of the attending physicianMedications are administered either 60 minutes before or after the scheduled time, except before or after meal orders, which are administered (based on mealtimes)"					
	3.1-25(b)(9) 3.1-48(c)(1)					

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	OF CORRECTION	IDENTIFICATION NUMBER:  155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	COM	IE SURVEY IPLETED 21/2012
	PROVIDER OR SUPPLIE		STREET A 814 S 6 MONTIO	P CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY O	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
	3.1-48(c)(2)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED		
		155782	B. WING		12/21/2012
				ADDRESS, CITY, STATE, ZIP CODE	<u>l</u>
NAME OF I	PROVIDER OR SUPPLIE	R		STH ST	
WHITE C	OAK HEALTH CAM	DLIC		ICELLO, IN 47960	
VVIIIIE	AK HEALTH CAIN		MONT		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0361 SS=D	FOOD SVCS The facility must either full-time, pasis.  If a qualified diet full-time, the facility serve as the creceives frequer from a qualified.  A qualified dietiti based upon eith Commission on American Dietet basis of educatic identification of implementation. Based on recointerview, the the Dietary Mawith the Registensure the facineeds of each fluid restriction reviewed for fluid restriction reviewed for fluid restriction (Resident #95).  Findings included the facility of the facilit	an is one who is qualified er registration by the Dietetic Registration of the ic Association, or on the on, training, or experience in dietary needs, planning, and of dietary programs. Ord review and facility failed to ensure anager (DM) worked tered Dietician (RD) to cility met the nutritional resident, related to a for 1 of 2 residents uid restriction.  )  de:  s record was reviewed to serious and the seriou	F0361	1. Resident #95 no longer res at the facility.2. Residents with physician's orders for fluid restriction have potential of be at risk of alleged deficient practice. Charts of current residents with physician's order for fluid restriction will be approved for compliance and appropriate documentation.3. Director of Food Services (DF will be in-serviced on working the Registered Dietician (RD) ensure the facility meets the nutritional needs of the reside according to the DFS job description.4. DHS or designe will review fluid consumption feach resident with physician's orders for fluid restriction 5x's/week x 2 weeks, 3x's/weef for 2 weeks, weekly x 2	ers The (S) with to ee for

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIWINDING	00	COMPLETED	
		155782	A. BUILDING		12/21/2012	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	R				
WHITE C		DUE	814 S 6TH ST MONTICELLO, IN 47960			
WHILE	OAK HEALTH CAM	PUS	MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	· ·	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	A physician's o	order, dated 12/07/12,		months and monthly x 3 mont	hs	
	indicated to lin	nit the resident's fluids		to ensure compliance. Audit	41-1.	
	to one liter (10	00 cubic centimeters)		results will be brought to mon Quality Assurance (QA)	tniy	
	(cc) per day.	,		meetings. Trends will be review	wed	
				by QA Committe x 6 months of		
	The resident's	fluid intake record the		until 100% compliance is		
	following daily			achieved.		
	12/08/12-1440					
	12/08/12-1440					
	12/10/12-1380					
	12/11/12-1120 cc					
	12/12/12-1140					
	12/13/12-1230	cc				
	12/14/12-900	CC				
	12/15/12-1660	cc				
	12/16/12-1224	· cc				
	During an inte	rview on 12/17/12 at				
	_	N #11 indicated the				
	· ·	red 90 cc of fluid with				
		on pass. She indicated				
		d not get medications				
		y give the resident 180				
	cc's of fluid wit	<del>-</del>				
		ss. (360 cc/day with				
	medication pa	ss)				
	During an inte	rview on 12/17/12 at				
	9:29 a.m., the	Dietary Manager (DM)				
	· ·	esident received 213				
		She indicated the				
	Registered Die					
		are plan on fluid				
		•				
		he DM indicated she				
	does not write	care plans or				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		(X2) MULTIPLE C  A. BUILDING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/21/2012
	PROVIDER OR SUPPLIE		814 S	ADDRESS, CITY, STATE, ZIP CODE 6TH ST ICELLO, IN 47960	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)	(X5) COMPLETION DATE
	indicated she of assessments. nurse commur restriction throform and then information on card. She indiffund aware the redaily. She indiffund Boost had alrest the nurses' fluit Registered Discresidents weel last time the Reseased the nurses' fluit residents weel last time the Reseased the nurses' fluit residents weel last time the Reseased the nurse of the nursing secharted dietary informative and services provides provides of the nurse of the nurse of the nursing secharted dietary informative and services provides of the nurse of th	the resident's tray cated she was esident received Boost icated she thought the eady been included into ds. She indicated the etician (RD) checks the kly. She indicated the egistered Dietician had resident was on  Tryiew on 12/17/12 at DM indicated the RD and of the fluid  If Dining Services job ated 10/09, received as the DM on 12/18/12 at cated, "Process diet are diets as received ervicesEnsure that are progress notes are diets and the resident's the serviceAssist in			

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	of Correction identification number:  155782	(X2) MUL A. BUILD B. WING		00	COMPL 12/21/	ETED		
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS		STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE		
	dietary needs of each resident. Assist in developing a written dietary plan of carethat identifies the dietary problems/needs of the residentReview and revise care plans and assessments as necessary"  3.1-20(a)							

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155782	B. WINC	ì		12/21/	2012
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAM	PUS			CELLO, IN 47960		
					02220, 117 17 000		(X5)
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	483.65						
SS=F		NTROL, PREVENT					
	SPREAD, LINEN						
		establish and maintain an Program designed to					
		anitary and comfortable					
		to help prevent the					
		transmission of disease					
	and infection.						
	(a) Infection Conf	trol Program					
	The facility must	establish an Infection					
	Control Program under which it -						
		controls, and prevents					
	infections in the f	•					
		procedures, such as					
		be applied to an individual					
	resident; and	ecord of incidents and					
	· '	s related to infections.					
	Corrective actions	s related to infections.					
	(b) Preventing Sr	oread of Infection					
		ection Control Program					
	· '	a resident needs isolation to					
	prevent the sprea	ad of infection, the facility					
	must isolate the r	resident.					
	(2) The facility m	ust prohibit employees with					
		disease or infected skin					
		ct contact with residents or					
		ct contact will transmit the					
	disease.	ust require staff to week					
		ust require staff to wash each direct resident contact					
		rashing is indicated by					
	accepted profess						
	accepted profess	nonai pidolioc.					
	(c) Linens						
		nandle, store, process and					
		so as to prevent the spread					
	of infection.						
			F044	11	1. Residents #1, #3, #12, #13	,	01/20/2013
	Based on obse	ervation, record review,			#23, #24, #51, #55, #56, #48	and	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLI	ETED
		155782	B. WIN			12/21/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L.		814 S 6			
WHITE O	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	and interview,	the facility failed to			#67 had no adverse affects		
	follow infection	control guidelines,			noted.2. Residents residing at		
	related to not v	•			facility have potential to be at a		
		ching residents during			of alleged deficient practice. S in each department will be	тап	
		ervice, which had the			in-serviced on proper		
		ect 36 residents who			handwashing practices. Nursir	ng l	
	•	eir meal in the dining,			staff will be in-serviced on prop	-	
		ands after resident			cleaning techniques of equipm	ent	
	_	nitizing equipment			for multi-resident use, proper		
					storage of items that belong to individual residents in resident		
	used for multiple residents after use, storing opened packages of briefs on the floor, soiled urine collection				rooms and in treatment carts a		
					education to nursing staff relat		
	,				to dedicated equipment for		
	containers unc				residents in isolation.3. Directo	or of	
		resident toothbrushes			Health Services (DHS) or		
		abeled in the bathroom			designee will conduct rounds of units at various times to include		
		(200 and 300), not			checking resident bathrooms a		
	•	se/assigned supplies			treatment carts for proper stora		
		ion rooms (Residents			of personal items, observation	-	
		3, #23, #24, #51, #55,			proper handwashing practices		
		#67) (Dietary Manager			during meals, during care, dur	-	
	, ,.				•	OI	
		•					
	and RN #13), a	and storing open and			those residents in isolation.		
	•	ectant in the treatment			Rounds will be conducted 5 x's		
	carts without be	eing separated (100,			/week x 1 month, then weekly	x 5	
	200, and 300 u	init). This had the					
	potential to affe	ect 55 of 55 residents			, , ,		
	residing in the	facility.			, , ,	.	
	-				Committee x 6 months or until		
	Findings includ	le:			100% compliance is achieved.		
	1. During an ob	oservation on 12/13/12					
	_	N #13 obtained					
	-						
		f and also obtained the					
	(DM), LPN #3, #8 Restorative and RN #13), a used skin protecarts without be 200, and 300 upotential to afferesiding in the Findings included 1. During an obat 7:33 a.m., R Resident #1's be	LPN #4, CNA #5, CNA Aide #6 Cook #10, and storing open and ectant in the treatment eing separated (100, anit). This had the ect 55 of 55 residents facility.  de:  Deservation on 12/13/12 N #13 obtained blood pressure with a			medication pass, observation of proper cleaning of equipment used by multiple residents and those residents in isolation.  Rounds will be conducted 5 x's /week x 1 month, then weekly months.4. Audit results will be brought to monthly Quality Assurance (QA) meetings.  Trends will be reviewed by QA Committee x 6 months or until	of I S x 5	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON SOITEEL	•		814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident's oxyg	en saturation with the					
	facility's oxeme	eter.					
	RN #13 then left the resident's room						
	-	th the blood pressure					
		eter in a basket on top					
		on cart. RN #13 did not					
		ms prior to placing the					
	items in the ba	sket.					
	2. During an o	bservation on 12/14/12					
	at 10:03 a.m.,	LPN #4 listened to					
	Resident #67's	breath sounds and					
	obtained the re	esident's oxygen					
	saturations wit	h the facility's					
	oxemeter. The	stethoscope was then					
	placed around	the back of LPN #4's					
	neck, and LPN	#4 then left the					
	resident's room	n without washing her					
	hands or saniti	zing the oxemeter.					
	LPN #4 then pl	laced the oxemeter in a					
	basket on top o	of the medication cart					
	and began lool	king through her					
	Medication Adı	ministration Records					
	and pulled the	medication cart down					
	the hallway.						
	During an inter	view on 12/14/12 at					
	_	N #4 indicated she					
	·	inds every three					
	residents and u	-					
		ents. She indicated					
		uched the stethoscope,					
	_	she did not wash her					
,	1 -0	314 1101 114011 1101	1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		dicated she sanitizes					
		e with alcohol every					
	•	indicated she was					
	_						
	unsure what the policy was for sanitizing the stethoscope and oxemeter. She indicated she does not						
	sanitize the ste	•					
		een residents. She					
		uld be a good idea if					
		washed between					
	residents. She	e indicated if the					
	resident was re	eally sick she would					
	wipe the oxime	eter finger probe with					
	alcohol gel.						
	3						
	An undated fac	cility policy, titled,					
		Cleaning Guidelines",					
	received as cu	•					
		on 12/14/12 at 11 a.m.,					
		o prevent cross					
	· ·	•					
	contamination	_					
		etween residents					
		stethoscope is used by					
	•	nembersGather					
	•	ohol wipes or a bottle					
		cotton balls to clean					
	the stethoscop	eUsing firm pressure,					
	clean the steth	oscope ear pieces,					
	tubing, diaphra	igm and bell in a					
	circular motion	with alcohol wipe or					
		l (sic) cotton ball"					
		-					
	3. On 12/13/1	2 at 4:00 p.m., LPN #3					
		assessing Resident					
		wn stethoscope and					
	TOT WILLTIEF O	wir stetrioscope and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
NAME OF I	DOLUBER OR GURRU IEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		814 S 6	TH ST		
WHITE C	OAK HEALTH CAMI	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	placed it back	around her neck then					
	applied a pulse	e oximeter probe					
	around the res	ident's finger.					
		-					
	LPN #3 left the	e room and placed the					
	pulse oximeter machine back in basket with other equipment without						
	being cleaned.						
	LPN #3 had placed Resident #67 nebulizer machine on the floor while the resident was receiving treatment.						
		ar recomming a comment					
	LPN #3 left the	e room again and					
		sident #67's room with					
		meter and took the					
		perature in her ear.					
		isposed the cover in					
		and left the room					
		ng the thermometer and					
		~					
	washing hands	<b>.</b>					
	I DN #3 came I	back into the room to					
		nt if she wanted					
	1 -	ed back to medication					
	· ·	k to the resident's room					
		about her pain					
	1	back to the medication					
		ed to the resident's					
		ne Tylenol and restarted					
		LPN #3 left the room					
	without cleaning any equipment, her						
	stethoscope, o	r washing her hands.					
		yent to Regident #60's					
	LEN#3 (nen W	ent to Resident #60's					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155782	B. WIN	G		12/21/2012
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			814 S 6	TH ST	
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		ked the resident's				
	•	with an electric, wrist				
	monitor and pu	t the monitor back in				
	basket with oth	er equipment on the				
	medication car	t without cleaning it.				
	LPN#3 then pro	epared Resident #60's				
	medication and	I took it to the resident.				
	At this time, LP	N #3 washed her				
	hands.					
	LPN #3 was the	en observed to return				
	to her medicati	on cart, go into				
		room, then went back				
		7's room and returned				
	to her medicati					
	to rici inicalcati	on cart.				
	LPN #3 was the	en observed to remove				
	a bag of trash	on the side of the cart.				
	LPN #3 had go					
		•				
		′ <b>!</b>				
		•				
	_	•				
		and gone into Resident				
	#67's room.					
	LPN #3 then re	emoved Resident #67's				
	•					
	•					
	medication car oximeter mach her arm. LPN: Resident #13's bed up, gave in head of the bed the room withound grabbed the under her arm #67's room.  LPN #3 then remask, placed it placed the neb	t, grabbed the pulse ine and placed it under #3 returned to room, put the head of nedication and put the d back down. She left ut washing her hands he pulse oximeter from and gone into Resident				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155782	B. WIN	G		12/21/2012
NAME OF B	DOWNER OF CLIDE IEE			STREET A	DDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			814 S 6	TH ST	
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		dent's chair while she				
		esident's lung sound				
		scope again. LPN #3				
		cope back around her				
		ashing it. LPN #3				
		se oximeter on the				
		side table, assisted the				
		bathroom. LPN #3 did				
		s but she brought the				
	-	back out to the				
	medication car	t and didn't clean it.				
	4. LPN #4 wa	s observed on				
		i4 a.m., to go into				
		room and turned off				
		nachine. LPN #4				
		esident lungs with her				
	•	nd walked out of room				
		g hands or cleaning				
		e. The pulse oximeter				
		ne resident and was				
	· •	to the basket on the				
	medication car	t without being				
	cleaned.					
	An undated fac	cility policy, titled,				
		aning Guidelines",				
		rrent from the Director				
	of Nursing (Do	N) on 12/14/12 at 11				
	,	, ""To prevent cross				
		when using a Pulse ox				
	between residents and/or when a					
		ic) is used by multiple				
	. ,	Gather disposable				
		or a bottle of alcohol				
						ĺ

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
NAME OF I			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	K		814 S 6	TH ST		
	OAK HEALTH CAM				CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
		ls to clean the Pulse					
	_	pressure, clean the					
	Pulse ox, wires, probe in a circular motion with alcohol wipe or alcohol socked (sic) cotton ball"						
	_	nterview on 12/14/12 at					
	· · · · · · · · · · · · · · · · · · ·	e DoN indicated the					
		olation have their own					
	blood pressure	e cuff and equipment.					
	She indicated	they are either kept in					
	the room or in the drawer in the isolation dresser.						
	During an obse	ervation of Resident					
	#48's room, wi						
	•	esent, there were no					
	1	e cuff and stethoscope					
	•	room or in the isolation					
	dresser.						
	During an inter	rview at the time of the					
	_	ne Nurse Consultant					
	•	esident had Clostridium					
	Difficile (C-Diff						
		<i>)</i> ·					
	During an inter	rview at the time of the					
		PN #4 indicated she					
		d pressure cuff into the					
	_	e resident's blood					
	·	e indicated she had					
		ood pressure cuff and					
	•	or the resident but they					
		ailable for the resident.					
	She indicated	she cleaned her					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SU	JRVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLE	
		155782	B. WIN	G		12/21/2	012
NAME OF P	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE C	OAK HEALTH CAMI	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	<u> </u>	DATE
		ith alcohol after she					
	used it for the resident. She indicated she did not sanitize the blood pressure cuff.  An undated policy, received from the						
	· •	t on 11/14/12 at 1:10					
		ontact Precautions",					
	l •	contact Precautions ,					
	· ·	event and control					
		insmission of infection					
		following:Clostridium					
		edureDedicated					
		resident or the					
	1	uipment between					
		quiredA stethoscope,					
		ometer (blood pressure					
	' ' '	neter should be					
	l '	dividual residents. If					
	use of commo						
		hen adequate cleaning					
		g is necessary before					
	use with other	~					
	6. During an c	observation on 12/11/12					
	at 11:19 a.m. F						
		ained a toothbrush in a					
		h bristles uncovered					
		eathroom sink (shares					
		another resident).					
	During an into	rview at the time of the					
	_	e resident stated the					
		s hers. She stated					
	l mere was no d	other place to keep					

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		155782	B. WIN			12/21/	2012
			Б. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	PROVIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	them.						
	During an obse	ervation on 12/17/12 at					
	_	the Maintenance					
	Director and the						
		, Resident #23's					
		ained a toothbrush in a					
		n bristles uncovered					
	sitting on the b	athroom sink.					
	7. On 12/11/12	2 at 10:09 a.m.,					
	Resident #55 a	and #56's tooth brushes					
	were observed	in the bathroom, on a					
		ed in a cup. A white					
	measuring coll						
	_						
		nd the toilet on the					
	floor, uncovere	ed.					
	On 12/13/12 at	t 9:21 a.m., Resident					
	#55 and #56's	tooth brushes were					
		e bathroom on a table,					
		xt to the toilet. A					
	•	ontinent briefs was					
	ı ·						
		e floor opened, next to					
	the toilet. A wh	•					
		vas observed behind					
	the toilet on the	e floor, uncovered.					
	0 44/44/40	144.00 a.m. Deeldeet					
		t 11:00 a.m., Resident					
		oothbrushes was					
	observed on in	the bathroom on a					
	table, uncovere	ed, next to the toilet. A					
		ontinent briefs was					
		e floor opened, next to					
		a soiled washcloth					
		a conca washoldti					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPLI	ETED
		155782	B. WIN			12/21/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA:	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	observed on ba	athroom floor.					
	8. During an o	bservation of the 200					
	_	t Cart on 12/17/12 at					
		LPN #12 present,					
	•	nerous opened/used					
		•					
	•	rotectant ointments					
		ames on tubes,					
		other in the bin of the					
	treatment cart.						
	acknowledged	the tubes were not					
	stored in a san	itary manner.					
	During an obse	ervation of the 100 Unit					
	_	t on 12/17/12 at 3:03					
		#14 present, there were					
		•					
	•	ned/used tubes of skin					
	•	ments with resident					
		es, touching each other					
		e treatment cart. RN					
		lged the tubes were not					
	stored in a san	itary manner.					
	During an obse	ervation of the 300 Unit					
	Treatment Car	t on 12/17/12 at 3:07					
		#15 present, there were					
		ned/used tubes of skin					
	•	ments with resident					
	l '						
		es, touching each other					
		e treatment cart. RN					
		lged the tubes were not					
	stored in a san	itary manner.					
	9 During dinin	g observation in the					
	J. During untill	g observation in the					

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Event ID: KGNH11

Facility ID: 012355

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLI	ETED
		155782	B. WIN			12/21/2	2012
			Э. W II V		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6			
WHITE O	OAK HEALTH CAMI	PUS		1	CELLO, IN 47960		
				<u> </u>	02220; IIV 17000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		oom, on 12/11/12 at					
	12:25 P.M.,Co	ok #10 was serving					
	plates at the st	eam table without the					
	use of gloves when she went into the						
	kitchen by pus	hing the swinging door					
		pare left hand. Cook					
		nd continued to serve					
		es without washing her					
	hands or witho	_					
		el which is mounted to					
		the kitchen door.					
		re thumbs were					
		on the topside of each					
	plate as she w	as serving the food.					
	On 12/11/12 at	t 12:34 P.M., Cook #10					
	was again obs	erved to leave the					
	serving line to	enter the kitchen					
		or open with her bare					
		urned to serving plates					
		g her hands or using					
	antibacterial ge	_					
	antibacienai ye	JI.					
	00 10/11/10 5	obugon 12:25 to					
		petween 12:35 p.m. to					
		DM (Dietary Manager)					
		to have touched a					
	resident while	placing a clothing					
	protector on th	em and went to the					
	steam table, pi	cked up a tray of food					
	and passed it	out to the residents.					
	1	observed coming into					
		id began passing out					
		nts in the smaller dining					
		not wash her hands/use					
	nand sanitizer	prior to passing out the					

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Event ID: KGNH11

Facility ID: 012355

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	OF CORRECTION  IDENTIFICATION NUMBER:  155782	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 12/21/2012			
	PROVIDER OR SUPPLIER  DAK HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE			
	tray of food. The DM was observed to have her hand on resting on the top of her head while holding a tray, walked to the fluid area, grabbed a glass, walks into the kitchen. The DM came out with milk in a glass and delivered it to a resident. The DM bends over speaking to a resident and touches her legs, grabs another glass off of the table, walked to the fluid area, fills the glass with juice and returns it to the resident. Again, she touches her legs, took a plate off of a table and took it to a counter, cuts up the food on the plate and returns it to the resident. The DM touches a resident's wheel chair, touches another resident and then washes her hands.  On 12/11/12 at 12:44 P.M., the Dietary Manager (DM), who was assisting in delivering plates by tray, was observed going into the kitchen using her bare hands on the door. The DM came out of the kitchen holding individual serving size dishes in her hand. Without washing her hands or using antibacterial gels, the DM proceeded to serve plates with bare hands.  On 12/11/12 at 12:49 P.M., the DM went into the kitchen, opened the door with her bare hands and						

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PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED	
		130702	B. WIN		DDDEGG CITY COLOR CO.	12/21/	
NAME OF F	ROVIDER OR SUPPLIER	8		814 S 6	ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAM	PUS			CELLO, IN 47960		
					02220, IIV 17000		are)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
		glass of liquid. She		0			D.112
		continue serving with no					
	hand washing	•					
	mand washing	or ger.					
	On 12/11/12 at	t 12:53 P.M., Cook #10					
		itchen using her bare					
		oor and came out with a					
	stack of clean						
		erve food onto plates					
	•	g her hands or using					
	gel.	g ner namas er asmig					
	goi.						
	10 On 12/13/	12 at 8:45 a.m., RA #6					
		de) was observed					
	•	sident #12 up in the					
	_	then started to pass					
		plate to Resident #51.					
		positioned Resident #1					
	-	nair and began passing					
		eakfast plate to 2 other					
		#6 then repositioned					
		wheel chair under the					
		othing protector on the					
	•	sat down between					
		and #12. RA #6 began					
		ent #24 with breakfast					
	10 000101 175010	CIII #24 WIIII DI CANIASI					

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Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
		_	-	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	PROVIDER OR SUPPLIEF	₹		814 S 6	TH ST		
WHITE C	AK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	STIMMADVS	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		und and wiped of	+	1110			
		? mouth. At this time					
	_	up and sanitized her					
	hands.						
	CNA #5 came into the small dining room and picked up a plate of food						
		t to Resident #13 and					
	_	t her with her meal.					
	CNA #5 wiped Resident #13's mouth						
	off with a towel, clipped wheel chair alarm to the resident and began to						
		t #1 by cutting up a					
		CNA #5 returned to					
	Resident #13 a	and wiped off her face					
	and left to go to	o the kitchen to get					
	another bowl o	f oatmeal for Resident					
	#1. CNA #5 re	turned with a bowel of					
	oatmeal, move	ed a chair from					
	Resident #13's	table to Resident #3					
	table and sat ir	n between Resident #3					
	and #51. CNA	45 then got up and					
		Resident #55 and cut					
		on role. CNA #5 then					
	started to cut F						
	cinnamon role.						
		•					
	CNA #8 came	into dining room,					
	sanitized her h	•					
		for Resident #56 then					
		esident #3, then					
		,					
		es from Resident #12.					
	CNA #8 sanitiz						
		dent #51 clothing					
	protector, remo	oved the resident from					

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	of Correction identification number: 155782	(X2) MULTIPLE C  A. BUILDING  B. WING	00	COMPLETED 12/21/2012
	PROVIDER OR SUPPLIER DAK HEALTH CAMPUS	814 S	ADDRESS, CITY, STATE, ZIP 6TH ST ICELLO, IN 47960	CODE
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	the dining room. Resident #3 asked for a glass of milk and CNA #8 took the glass from the table and returned with milk. CNA #8 did not sanitize her hands. When CNA #8 did sanitize her hands, she removed a clothing protector from Resident #56, touched the residents wheel chair, then touched Resident #3 plate to encourage the resident to eat.  RA #6 and CNA #8 were interviewed during this time. Both indicated hand washing or sanitizing should be done in between each resident contact.  3.1-18(I) 3.1-19(r)(1)(2)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S COMPLI		
ANDILAN	or connection	155782	A. BUI	LDING		12/21/	
		133762	B. WIN	_		12/2 1/.	2012
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
WHILE C	OAK HEALTH CAME	70S		MONTI	ICELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0465	483.70(h)						
SS=E		NAL/SANITARY/COMFOR					
	TABLE ENVIRON	v provide a safe, functional,					
		nfortable environment for					
	residents, staff ar						
	Based on obse		F04	65	1. Residents #58, #64, #30, #	54.	01/20/2013
	interview.the fa	icility failed to provide a			#55 and #56 had rooms and	,	
		omfortable environment			equipment cleaned at the time	of	
	,	elated to urine odors in			survey to address alleged		
		(Residents #58 and			deficient practice. No adverse affects were noted. 2. Resider		
#64), Accumulation of dust on a		•			receiving care at this facility ha		
	dresser and TV (Resident #30), opened bag of briefs stored on				potential to be at risk of allege		
					deficient practice. Rounds will		
					conducted by Director of Plan	t	
		s (Residents #30, #55,			Operations (DPO) or designed		
	· ·	soiled urine collection			identify any resident rooms wi		
		ed in the bathroom			urine odors, dust and/or open- bags of briefs stored on bathro		
	,	l, #55, and #56) during			florrs and/or soiled urine	50111	
		observations for 2 of 3			collection containers stored in		
	units.				bathroom. DPO will provide		
					results to Director of		
	Findings includ	le:			Environmental Services (DES		
					DES and environmental service staff will be in-serviced on	ces	
	1. During an o	bservation on 12/11/12			providing sanitary and		
	at 11:17 a.m., t	there was an			comfortable environment for		
	accumulation c	of dust on Resident			residents. DES or designee w	ill	
	#30's dresser a	and TV. There were			conduct rounds of resident		
	three opened b	pags of briefs stored on			rooms 5 x's/week x 1 month, 3		
	the floor of the	•			x's/week x 1 month, then week	-	
					x 4 months on various units at various times to ensure	·	
	During an obse	ervation on 12/17/12 at			compliance with odors, dust a	nd	
	_	the Director of			proper storage of personal ite		
		and the Maintenance			in resident bathrooms.4. Audit		
Director present, there was an			results will be brought to mont	hly			
	•	of dust on the resident's			Quality Assurance (QA)	wod	
		/. There were two			meetings. Trends will be revie by QA Committee x 6 months		
	l aresser ariu I V	. THELE WELE LWO			by with committee x o months	<b>υ</b> ι	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155782	A. BUI	LDING	00	COMPL 12/21/	
		100702	B. WIN			12/21/	2012
NAME OF F	PROVIDER OR SUPPLIEF	₹		814 S 6	ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.ΤΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	opened bags of floor of the bat	of briefs stored on the hroom.			until 100% compliance is achieved.		
	observation on of Housekeepi	rview at the time of the 12/17/12, the Director ng indicated the ns are dusted daily.					
	at 10:53 a.m.,	observation on 12/11/12 there was a strong n Resident #58's					
	During an interview at the time of the observation, LPN #11 indicated the bathroom, "needs attention".						
	at 4:32 p.m. wi Maintenance p	observation on 12/13/12 ith the Director of present, there was a urine in the room and esident #64.					
		ervation on 12/17/12 at e was a urine odor in s bathroom.					
	Director of Mai Housekeeping 12/17/12 at 1:2	ervation with the intenance and the Director present on 25 p.m., there was a esident #64's room and					
	During an inter	view at the time of the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF B	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	· ·	e Housekeeping					
	Director indicated there was a soiled brief in the resident's trash can in the bathroom. She indicated the CNA's						
		ken the soiled brief out					
	of the room.						
	4 05 40/44/40	at 40,05 a					
		at 10:05 a.m., a white					
		ection hat with dried					
	1 -	ce was observed in a					
		n the wall and the toilet,					
	· ·	covered in Resident					
	#54's bathroon	1.					
	Op 12/11/12 at	: 10:09 a.m., a white					
	measuring coll	-					
		nd the toilet on the					
		d in Resident #55 and					
	#56 room.	d iii Nesidelit #35 alid					
	#30 100111.						
	On 12/13/12 at	: 9:21 a.m., a package					
		oriefs was observed on					
		ed, next to the toilet. A					
	· ·	ng collection hat was					
		nd the toilet on the					
		d in Resident #55 and					
	#56 room.	a iii Nesident #55 and					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	On 11/14/12 at	: 11:00 a.m., a package					
		oriefs was observed on					
		ed, next to the toilet.					
		, none to the tollet.					
	3.1-19(f)						

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PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00		LETED
		155782	B. WING			/2012
	ROVIDER OR SUPPLIER		814 S 6	ADDRESS, CITY, STATE, ZIP COD TH ST CELLO, IN 47960	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
			•			•

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Event ID: KGNH11

Facility ID: 012355

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING	00	COMPL	ETED
		155782	B. WING	ING		12/21/	2012
				CTDEET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6			
WHITE O							
WHITE O	AK HEALTH CAMF	<sup>2</sup> 08	- [ ]	MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
F0520	483.75(o)(1)						
SS=F	QAA COMMITTE	E-MEMBERS/MEET					
	QUARTERLY/PL	ANS					
	A facility must ma	nintain a quality					
		assurance committee					
	_	director of nursing services;					
		nated by the facility; and at					
	least 3 other men	nbers of the facility's staff.					
	III						
		sment and assurance					
committee meets at least quarterly to identify issues with respect to which quality							
	•	assurance activities are					
		evelops and implements					
	•	of action to correct					
	identified quality						
	identified quality (	deficiencies.					
	A State or the Se	ecretary may not require					
		records of such committee					
		such disclosure is related					
	•	e of such committee with					
	the requirements						
	·						
	Good faith attemp	ots by the committee to					
	identify and corre	ct quality deficiencies will					
	not be used as a	basis for sanctions.					
			F0520	)	1. Residents #1, #3, #12, #13,	ļ	01/20/2013
	Based on recor	rd review and interview			#23, #24, #51, #55, #56, #48 a	ınd	
		sure the facility QAA			#67 had no adverse affects	ļ	
		<del>-</del>			noted. Quality Assurance (QA)	)	
	•	sment and Assurance)			Committee will be notified of		
		tified system failure			infection control system failure	ļ	
	•	ection control, which			not being identified by the QA	ļ	
	had the potenti	al to affect 36			Committee.2. Residents residing	•	
		eat in the Main Dining			at this facility have potential to	be	
		Residents who reside			at risk of alleged deficient	ļ	
					practice. QA Committee will		
		(100, 200, and 300			develop systems to be reviewed		
	•	d the potential to affect			monthly to ensure system failu		
	55 of 55 reside	nts who reside in the			can be identified. Action Plans	WIII	
					be implemented for systems		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMI	COMPLETED	
		155782	A. BUILDING B. WING		<b>–</b> 12/2	1/2012	
			_	EET ADDRESS, CITY, STATE, ZIP C	ODE		
NAME OF P	PROVIDER OR SUPPLIE	R		4 S 6TH ST	OBL		
WHITE C	OAK HEALTH CAM	PLIS		NTICELLO, IN 47960			
	ARTIEAETH OAW		I				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREF	CROSS-REFERENCED TO THE A		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)	TAC			DATE	
1	the facility. (R	esidents #1, #3, #12,		identified which include			
	#13, #23, #24,	#48, #51, #55, #56,		monitor and compliand			
	and #67) (LPN	I #3, LPN #4, CNA #5,		date.Staff in each depa			
	RA #6. CNA #	8, Cook #10, LPN #12,		be in-serviced on prophandwashing practices			
	RN #13, RN #14, RN #15, and			staff will be in-serviced	-		
	Dietary Manag			cleaning techniques of			
		JOI /		for multi-resident use,			
	   Finalina: a la ales	do.		storage of items that b			
	Findings include	ae:		individual residents in	esident		
	1. During an observation on 12/13/12 at 7:33 a.m., RN #13 obtained Resident #1's blood pressure with a			rooms and in treatmen	t carts and		
				education to nursing st			
				to dedicated equipmen			
				residents in isolation. 3			
	digital wrist cu	ff and also obtained the		of Health Services (DF			
	_	gen saturation with the		designee will conduct runits at various times t			
	facility's oxime			checking resident bath			
		ici.		treatment carts for proj			
	DN #40 #5 5 5 1	6. 4b		of personal items, obse			
		eft the resident's room		proper handwashing p			
	•	th the blood pressure		during meals, care and	I		
	cuff and oxem	eter in a basket on top		medication pass, obse			
	of the medicat	ion cart. RN #13 did not		proper cleaning of equ			
	sanitize the ite	ms prior to placing the		used by multiple reside			
	items in the ba	isket.		those residents in isola			
				Rounds will be conduc			
	2 During an o	observation on 12/14/12		5x's/week x 1 month, to x 5 months. 4. Audit re			
	_	LPN #4 listened to		be brought to monthly			
	•			meetings. Trends will b			
		s breath sounds and		by QA Committee x 6 r			
		esident's oxygen		until 100% compliance	is		
	saturations wit	-		achieved. Results will a			
		e stethoscope was then		indicate to QA Commit			
	placed around	the back of LPN #4's		in-services are effectiv			
	neck, and LPN	I #4 then left the		indicate they are not th			
	resident's room without washing her			in-services will be re-d	•		
		izing the oxemeter.		and implemented until compliance is achieved			
				Compilation is acideved	<b>.</b>		
	LPN #4 then p	laced the oxemeter in a					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782				ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE COMPL 12/21/	ETED
		100762	B. WIN			12/21/	2012
NAME OF I	PROVIDER OR SUPPLIE	R		814 S 6	ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAM	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY		DATE
		of the medication cart king through her					
		ministration Records					
		medication cart down					
	the hallway.	modication odit down					
	During an inte	rview on 12/14/12 at					
	10:06 a.m., LF	N #4 indicated she					
		ands every three					
		use alcohol gel					
		ents. She indicated					
		ouched the stethoscope,					
	1	she did not wash her dicated she sanitizes					
		be with alcohol every					
	· ·	indicated she was					
	_	ne policy was for					
		stethoscope and					
	oxemeter. She	indicated she does not					
		ethoscope and					
		veen residents. She					
		uld be a good idea if					
		e washed between					
		e indicated if the eally sick she would					
		earry sick site would leter finger probe with					
	alcohol gel.	icter iniger probe with					
	An undated fa	cility policy, titled,					
		Cleaning Guidelines",					
	received as cu						
		on 12/14/12 at 11 a.m.,					
		o prevent cross					
	contamination	•					
	stethoscope b	etween residents					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155782	B. WIN			12/21/2	2012
		l .	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	t.		814 S 6			
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	CLIMMADY C	TATEMENT OF DEFICIENCIES		ID			(V5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
TAG		· · · · · · · · · · · · · · · · · · ·	+	TAU			DATE
		stethoscope is used by					
	'	nembersGather					
	disposable alcohol wipes or a bottle						
	of alcohol and	cotton balls to clean					
	the stethoscop	eUsing firm pressure,					
	clean the steth	oscope ear pieces,					
	tubing, diaphra	igm and bell in a					
		with alcohol wipe or					
		(sic) cotton ball"					
		( /					
	3. On 12/13/12 at 4:00 p.m., LPN #3						
		assessing Resident					
		_					
		wn stethoscope and					
	l ·	around her neck then					
		e oximeter probe					
	around the resi	ident's finger.					
	LPN #3 left the	room and placed the					
	pulse oximeter	machine back in					
	basket with oth	er equipment without					
	being cleaned.						
	LPN #3 had pla	aced Resident #67					
	•	nine on the floor while					
	l life resident wa	as receiving treatment.					
		waana anain anai					
		room again and					
		sident #67's room with					
		neter and took the					
		perature in her ear.					
	LPN #3 then di	isposed the cover in					
	the bathroom and left the room without cleaning the thermometer and						
	washing hands	_					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	ETED
		155782	B. WIN			12/21/2	2012
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8		814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	STIMMADA S	TATEMENT OF DEFICIENCIES	1	ID		1	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
1710				1710	<u> </u>		DATE
		back into the room to					
	ask the resident if she wanted Tylenol, returned back to medication						
	cart, went back	to the resident's room					
	and asked her	about her pain					
	intensity, went	back to the medication					
	cart and return	ed to the resident's					
		e Tylenol and restarted					
	_	LPN #3 left the room					
	without cleaning any equipment, her stethoscope, or washing her hands.						
	Stethoscope, o	i washing her hands.					
	1 DN #0 #6 a.a	cont to Decident #00le					
		rent to Resident #60's					
		ked the resident's					
	blood pressure	with an electric, wrist					
	monitor and pu	it the monitor back in					
	basket with oth	ner equipment on the					
		t without cleaning it.					
		3					
	I PN#3 then pr	epared Resident #60's					
	•	took it to the resident.					
		PN #3 washed her					
	hands.						
		en observed to return					
		on cart, go into					
		room, then went back					
	to Resident #6	7's room and returned					
	to her medicati	on cart.					
	LPN #3 was th	en observed to remove					
	a bag of trash on the side of the cart.  LPN #3 had gone back to the						
	_						
		t, grabbed the pulse					
	oximeter mach	ine and placed it under					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN			12/21/	/2012
NAME OF I	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULTERE	X.		814 S 6	TH ST		
WHITE C	OAK HEALTH CAM	PUS		MONTIC	CELLO, IN 47960		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	her arm. LPN						
		s room, put the head of					
		nedication and put the					
	head of the bed back down. She left the room without washing her hands and grabbed the pulse oximeter from under her arm and gone into Resident						
	#67's room.  LPN #3 then removed Resident #67's						
	mask, placed it back into the bag and placed the nebulizer machine back on						
		pulse oximeter was					
		ident's chair while she					
		resident's lung sound					
		scope again. LPN #3					
	•	scope back around her					
		ashing it. LPN #3					
	1 '	se oximeter on the					
		side table, assisted the					
		bathroom. LPN #3 did					
		Is but she brought the					
	'	back out to the					
	medication car	t and didn't clean it.					
	   4. LPN #4_wa	as observed on					
	Ī	54 a.m., to go into					
		s room and turned off					
		nachine. LPN #4					
		resident lungs with her					
		nd walked out of room					
		ng hands or cleaning					
		e. The pulse oximeter					
		ne resident and was					
	i piaceu back in	to the basket on the	1				İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155782	B. WIN	IG		12/21/2	2012
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOTT EIEF			814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	medication car	t without being					
	cleaned.						
	An undated facility policy, titled,						
		aning Guidelines",					
	received as cu	rrent from the Director					
	of Nursing (Do	N) on 12/14/12 at 11					
	a.m., indicated	, ""To prevent cross					
	contamination	when using a Pulse ox					
	between reside	ents and/or when a					
	stethoscope (s	ic) is used by multiple					
	• •	Gather disposable					
		or a bottle of alcohol					
	-	s to clean the Pulse					
		pressure, clean the					
	_	s, probe in a circular					
		cohol wipe or alcohol					
	socked (sic) co	-					
	Socked (Sic) CC	Mon bail					
	5 During an ir	nterview on 12/14/12 at					
	_	e DoN indicated the					
	· ·	olation have their own					
		cuff and equipment.					
	•	they are either kept in					
		the drawer in the					
	isolation dress	Ել.					
	During an obse	ervation of Resident					
	#48's room, wi						
	•	sent, there were no					
	•	e cuff and stethoscope					
		room or in the isolation					
	dresser.						
	During on inter	ruiouu at tha tima af tha					
	uning an inter שטו	view at the time of the					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE	CONSTRUCTION	r í	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
		155782	B. WING			1/2012
NAME OF I	PROVIDER OR SUPPLIE	R		CT ADDRESS, CITY, STATE, ZIP COD	Е	
WHITE C	OAK HEALTH CAM	DITE		S 6TH ST TICELLO, IN 47960		
				110LLLO, 111 47 900		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION
TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
		ne Nurse Consultant	1110			) Bills
		esident had Clostridium				
	Difficile (C-Diff					
	Billione (o Bill	.,,.				
	During an inte	rview at the time of the				
	_	PN #4 indicated she				
		d pressure cuff into the				
		e resident's blood				
	_	e indicated she had				
	1 -	ood pressure cuff and				
		or the resident but they				
	-	ailable for the resident.				
	She indicated	she cleaned her				
	stethoscope w	vith alcohol after she				
	used it for the	resident. She indicated				
	she did not sa	nitize the blood				
	pressure cuff.					
	An undated po	olicy, received from the				
	DoN as currer	nt on 11/14/12 at 1:10				
	p.m., titled, "C	ontact Precautions",				
	indicated, "C	Contact Precautions are				
	indicated to pr	event and control				
	nosocomial tra	ansmission of infection				
	with any of the	e following:Clostridium				
	DifficileProce	edureDedicated				
		resident or the				
	cleaning of eq	uipment between				
		quiredA stethoscope,				
		ometer (blood pressure				
	,	neter should be				
		ndividual residents. If				
		n equipment is				
	unavoidable, t	hen adequate cleaning				
	and disinfecting	ig is necessary before				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00		ATE SURVEY OMPLETED	
		155782	A. BUII B. WIN	LDING G		<del>-</del> 12	/21/2012
	ROVIDER OR SUPPLIER			STREET A 814 S 6	.DDRESS, CITY, STATE, ZIP O TH ST CELLO, IN 47960	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	use with other  6. During an o at 11:19 a.m. F bathroom conta plastic cup with sitting on the b bathroom with  During an inter observation the toothbrush was there was no o them.  During an obse 1:25 p.m. with Director and th Housekeeping bathroom conta plastic cup with sitting on the b  7. On 12/11/12 Resident #55 a were observed table, uncovere measuring collobserved behir floor, uncovere  On 12/13/12 at #55 and #56's	residents"  bservation on 12/11/12 Resident #23's ained a toothbrush in a a bristles uncovered athroom sink (shares another resident).  view at the time of the e resident stated the shers. She stated ther place to keep  ervation on 12/17/12 at the Maintenance he Director of Resident #23's ained a toothbrush in a h bristles uncovered athroom sink.  2 at 10:09 a.m., and #56's tooth brushes in the bathroom, on a ed in a cup. A white ection hat was and the toilet on the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155782	B. WIN	G		12/21/2012	
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		$\neg$
NAME OF P	ROVIDER OR SUPPLIER	C.		814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	, ·	ontinent briefs was					
	observed on the floor opened, next to						
	the toilet. A wh	_					
	collection hat v	vas observed behind					
	the toilet on the	e floor, uncovered.					
	On 11/14/12 at	t 11:00 a.m., Resident					
	#55 and #56 to	othbrushes was					
	observed on in	the bathroom on a					
	table, uncovere	ed, next to the toilet. A					
	package of inc	ontinent briefs was					
	observed on th	e floor opened, next to					
	the toilet, and a	a soiled washcloth					
	observed on ba	athroom floor.					
	8. During an o	bservation of the 200					
		Cart on 12/17/12 at					
		LPN #12 present,					
		nerous opened/used					
		rotectant ointments					
		ames on tubes,					
		other in the bin of the					
	treatment cart.						
		the tubes were not					
	stored in a san						
		ital y mainton					
	During an obse	ervation of the 100 Unit					
		t on 12/17/12 at 3:03					
		#14 present, there were					
	l •	ned/used tubes of skin					
		ments with resident					
	·	es, touching each other					
		e treatment cart. RN					
		lged the tubes were not					
	stored in a san	itary manner.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155782	A. BUII	LDING	00	COMPL	
		100762	B. WIN			12/21/	2012
NAME OF F	PROVIDER OR SUPPLIER	1		814 S 6	ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  I SC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	During an obset Treatment Carrent, with RN # numerous open protectant ointreames on tube in the bin of the #15 acknowled stored in a san 9. During dining Main Dining Ro 12:25 P.M., Cooplates at the structure of gloves witchen by pushopen with her be #10 returned a food onto plate hands or without antibacterial get the wall next to Cook #10's bar observed to be plate as she was again obset serving line to pushing the do hand. She return to the pushing the dothand.	g observation in the com, on 12/11/12 at ok #10 was serving eam table without the when she went into the hing the swinging door coare left hand. Cook and continued to serve as without washing her out using the el which is mounted to the kitchen door. The thumbs were soon the topside of each as serving the food.  12:34 P.M., Cook #10 erved to leave the enter the kitchen or open with her bare turned to serving plates g her hands or using		IAU			DATE

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	INSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE C	OAK HEALTH CAME	-US 		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		petween 12:35 p.m. to					
	•	DM (Dietary Manager)					
		to have touched a					
		placing a clothing					
		em and went to the					
	•	cked up a tray of food					
	•	out to the residents.					
		observed coming into					
	-	nd began passing out					
		nts in the smaller dining					
		not wash her hands/use					
		prior to passing out the					
		he DM was observed					
		nd on resting on the					
	·	d while holding a tray,					
		luid area, grabbed a					
	_	to the kitchen. The DM					
		milk in a glass and					
		a resident. The DM					
	•	eaking to a resident					
		er legs, grabs another					
	_	table, walked to the					
		the glass with juice and					
		e resident. Again, she					
	`	gs, took a plate off of a					
		it to a counter, cuts up					
		e plate and returns it to					
		The DM touches a					
		el chair, touches					
	another reside	nt and then washes her					
	hands.						
	On 12/11/12 at	t 12:44 P.M., the					
	Dietary Manag	er (DM), who was					
	assisting in del	ivering plates by tray,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155782	B. WIN	G		12/21/2012	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA <sup>*</sup> DEFICIENCY)		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
		going into the kitchen					
	using her bare hands on the door.  The DM came out of the kitchen						
	_	ual serving size dishes					
		/ithout washing her					
	_	antibacterial gels, the to serve plates with					
	bare hands.	to serve plates with					
	Daie Hallus.						
	On 12/11/12 at	: 12:49 P.M., the DM					
		itchen, opened the					
	door with her b	•					
		glass of liquid. She					
		continue serving with no					
	hand washing	_					
	On 12/11/12 at	: 12:53 P.M., Cook #10					
		itchen using her bare					
		oor and came out with a					
	stack of clean	dishes. She					
	proceeded to s	erve food onto plates					
	l ·	g her hands or using					
	gel.	-					
	10. On 12/13/	12 at 8:45 a.m., RA #6					
	(Restorative Ai	de) was observed					
	assisting a Res	sident #12 up in the					
	wheelchair and	I then started to pass					
		plate to Resident #51.					
	RA #6 then rep	ositioned Resident #1					
	in her wheel ch	nair and began passing					
	out another bre	eakfast plate to 2 other					
	residents. RA	#6 then repositioned					
	Resident #12's	wheel chair under the					
	table, put on cl	othing protector on the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet Page 115 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF D	PROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	resident, then s	sat down between					
	Resident #24 and #12. RA #6 began						
	to assist Resid	ent #24 with breakfast					
	and turned aro	und and wiped of					
	Resident's #12	mouth. At this time					
	did RA #6 got ι	up and sanitized her					
	hands.						
		into the small dining					
	•	ed up a plate of food					
		t to Resident #13 and					
	_	t her with her meal.					
	•	Resident #13's mouth					
		l, clipped wheel chair					
		sident and began to					
	assist Residen	t #1 by cutting up a					
	cinnamon roll.	CNA #5 returned to					
	Resident #13 a	and wiped off her face					
	and left to go to	o the kitchen to get					
	another bowl o	f oatmeal for Resident					
	#1. CNA #5 re	turned with a bowel of					
	oatmeal, move	d a chair from					
	Resident #13's	table to Resident #3					
	table and sat ir	n between Resident #3					
	and #51. CNA	#5 then got up and					
	walked over to	Resident #55 and cut					
	up her cinnamo	on role. CNA #5 then					
	started to cut F	Resident #51's					
	cinnamon role.						
		into dining room,					
	sanitized her h	•					
		for Resident #56 then					
		esident #3, then					
	removed dishe	s from Resident #12.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

If continuation sheet Page 116 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPLE	ETED
		155782	B. WIN			12/21/2	2012
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
				<u> </u>			(V5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110	CNA #8 sanitiz	*		1110			BITTE
		•					
		dent #51 clothing					
	protector, removed the resident from the dining room. Resident #3 asked						
	_						
	for a glass of milk and CNA #8 took						
	•	the table and returned					
		A #8 did not sanitize her					
		CNA #8 did sanitize					
		removed a clothing					
	protector from	Resident #56, touched					
	the residents w	heel chair, then					
	touched Reside	ent #3 plate to					
	encourage the	resident to eat.					
	RA #6 and CN	A #8 were interviewed					
	during this time	e. Both indicated hand					
	washing or sar	nitizing should be done					
	in between ead	ch resident contact.					
	During an inter	view on 12/14/12 at 2					
		tor of Nursing indicated					
	l •	inservices on hand					
	1	he last one had been					
		indicated she and the					
		unds to monitor					
		ol practices and she					
		and trending of active					
	_	e indicated there had					
		to ensure hand					
		eing done and being					
	1	She indicated there is					
	•	ensure the inservices					
	are effective.						
	3.1-52(b)(2)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: KGNH11

Facility ID: 012355

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782			A. BUILDING  B. WING		COMPLETED  12/21/2012			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  814 S 6TH ST  MONTICELLO, IN 47960					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
R0000		State Residential re in accordance with	R0000	Submission of this plan of correction and credible allega does not constitute an admiss by the provider that the allegations are a true and accurate portrayal of the provisions of care in this facili Please accept this plan as s and our credible allegation of compliance. White Oak Health Campus submits this plan of correction as its letter of credi allegation and requests a des review with paper compliance considered in establishing the provider is in substantial compliance. We appreciate you consideration of this request.	sion ity. ame ible sk e be e			

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 118 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155782	B. WING		12/21/2012	
NAME OF P	DOMDED OF GLIDNIES		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		814 S	6TH ST		
	OAK HEALTH CAME	PUS	MONT	ICELLO, IN 47960		
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
R0241	410 IAC 16.2-5-4 Health Services -	· /· /				
		ation of medications and				
	` '	esidential nursing care shall				
		the resident 's physician				
		ervised by a licensed nurse				
		or on call as follows:				
		all be administered by				
	licensed nursing properties.	personnel or qualified				
	Based on obse	rvation, record review	R0241	1. Resident #95 received his	01/20/2013	
		the facility failed to		lunch during the time of the		
		ans' orders were		survey. He ordered a "special		
	· ·	ed to medications not		that was prepared in the kitch	en	
		d, medications not		and, therefore, didn't need to		
				receive any food from the stea		
	given as ordere	_		table. Resident #24 was provi		
	-	ordered, oxygen not		clean pants during the time of survey. No adverse affects we		
	administered a			noted.2. Residents receiving		
	, , ,	tests not completed		meals in the dining room have	e the	
	as ordered for	3 of 6 residents		potential to be affected by the		
	reviewed for ph	nysicians' orders in a		alleged deficient practice. Die	tary	
	total sample of	6. (Residents #105,		and Nursing staff will be		
	#124, and #132	2)		in-serviced on verifying reside	ents	
	•	,		present in the Dining Room receive their food before the fo	204	
	Findings includ	e·		is removed. Nursing staff will a		
	ago inioidd			be in-serviced on dignity issue		
	1. Resident #1	32 record was		related to residents' hair being		
				combed and clothing not bein		
		2/18/12 at 1:30 p.m.		soiled. 3. Meal Manager or		
		diagnoses included,		designee will conduct audits		
		nited to, hypertension		3x's/week x 1month, then wee	-	
	and osteoporos	Sis.		x 5 months to ensure all resid		
				in the Dining Room receive fo prior to food being removed a		
	The Physician's	s Recapitulation		that residents are in unsoiled	iiu	
	Orders, dated 1	12/12, indicated an		clothing with combed hair. 4.		
	order for a BMF	P (Basic Metabolic		Audit results will be brought to		
		lytes) every six months		monthly Quality Assurance (C		
	and alternate w	• •		meetings. Trends will be revie		

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 119 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(Comprehensiv	ve Metabolic Panel)			by QA Committee x 6 months	or	
	(more compret	nensive electrolyte test)			until 100% compliance is		
	everv six mont	hs, lipid panel every six			achieved.		
		months, and a fasting iron panel					
	every three months.						
	The record indicated the last lab tests						
	were complete	d on:					
	lipid panel com	ipleted was on					
	10/27/11						
	fasting iron par	nel was on 11/13/11					
	BMP was on 1	11/14/11 then on					
	8/24/12.						
	There was a la	ck of documentation a					
		completed on the					
	resident	r completed on the					
	resident						
	Domina ar a sa tarat	- i 40/40/40					
	•	view on 12/18/12 at					
	· ·	Medical Records LPN					
		abs had not been					
	obtained as or	dered.					
	2. Resident #1	124's record was					
	reviewed on 12	2/18/12 at 8:45 a.m.					
	The resident's	diagnoses included,					
		mited to, end stage					
		and pulmonary fibrosis.					
		and punitoriary horodo.					
	The Physician'	s Recapitulation					
		12/12, indicated an					
	•						
	order, dated 09	9/20/12 for daily weight					

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 120 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155782	B. WING			12/21/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹		814 S 6			
WHITE C	OAK HEALTH CAMI	PUS			CELLO, IN 47960		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE
	•	ma or a weight gain of					
	11 pound or loss of 6.6 pounds to the						
	Nephrologist.						
	The Vital Signs	s and Weight Record					
	_	esident's weight had					
		on 10/12 and 11/12.					
		ick of documentation to					
		sident's weight had					
	been obtained	daily as ordered.					
	_	view on 12/18/12 at					
	10:10 a.m., LP	N #16 indicated the					
	resident gets w	veighed at dialysis					
	three times a v	veek. She indicated a					
	daily weight wa	as not getting done at					
	the facility.	0 0					
	,						
	3 Resident #1	105's record was					
		2/18/12 at 11 a.m. The					
	_	noses included, but					
		d to, dementia, atrial					
	fibrillation, and	anemia.					
	A) The Physic	ian's Recapitulation					
	Orders, dated	12/12, indicated the					
	resident was to	receive a CMP and a					
	CBC (complete	e blood count) every					
	three months.						
	The last CBC r	results in the record					
		21/12. There was a					
		entation in the record to					
	indicate a CMF	P had been completed.					

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 121 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155782		A. BUI	LDING	ONSTRUCTION  00	(X3) DATE : COMPL 12/21/	ETED	
		1007.02	B. WIN		A DDDEGG CITY CTATE ZID CODE	12,21,	2012
NAME OF F	ROVIDER OR SUPPLIER	₹		814 S 6	ADDRESS, CITY, STATE, ZIP CODE		
WHITE C	OAK HEALTH CAME	PUS			CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	ND OF THE PARTY OF		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	,1L	DATE
	During an inter	view on 12/18/12 at					
	,	N #16 indicated the					
CBC's and CMP's had not been							
	completed as o	ordered.					
	B) The Physici	an's Recapitulation					
	•	12/12, indicated an					
	-	1) for verapamil (heart					
	,	0 milligrams daily, hold					
	the medication	if the pressure is less					
	than 100/50 or	the pulse is less than					
	60.						
	The Medication	n Administration					
		, dated 10/12, indicated					
	, ,	plood pressure and					
		peen obtained on					
	•	8, 6, 7, 15, 16, 18, 22,					
	24, 26, 27, 28,	29, 2012.					
	The 40/40 \$44	D indicated the					
		R indicated the					
	•	e had not been					
	20, and 21, 20	ctober 10, 14, 17, 19,					
	20, and 21, 20	14.					
	The 10/12 MAF	R indicated the					
	resident's bloo	d pressure was 88/54					
	on 10/10/12 an	id the verapamil had					
	been administe	ered.					
		ad 11/12 indicated the					
	•	ed 11/12, indicated the					
		d pressure and pulse obtained on November					
		3, 14, 15, 19, 22, 23,					
	27, 28, and 29,						
	21, 20, and 29,	, 2012.					

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 122 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155782	A. BUILDING	00	COMPLETED 12/21/2012
		100702	B. WING	ADDRESS CITY STATE ZID CODE	12/2 1/20 12
NAME OF F	PROVIDER OR SUPPLIER		814 S 6	ADDRESS, CITY, STATE, ZIP CODE	
WHITE C	OAK HEALTH CAME	PUS		CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE COMPLETION DATE
IAU	The 11/12 MAR resident's pulse obtained on No and 26, 2012.  The 11/12 MAR resident's pulse and the verapablood pressure 11/17/12 and 9 the verapamil h  The MAR, date resident's pulse obtained on De and 11, 2012.  During an inter 11:15 a.m., LP blood pressure been obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse of the pulse of the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse of the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated given) on the No could not remeded the pulse obtained indicated the verapamil h 18, 2012 and sinitials (indicated the verapamil h 18, 2012 and sinitials	R indicated the e had not been ovember 2, 21, 24, 25,  R indicated the e was 58 on 11/8/12 amil was given and the was 92/50 on 98/48 on 11/18/12 and had been administered.  Red 12/12, indicated the e had not been ecember 1, 2, 3, 5, 8, 9,  Indicated the es and pulses had not as ordered. She erapamil may have lovember 8, 17, and the just didn't circle the es medication not MAR. She indicated she	IAU		DATE

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 123 of 131

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMP:	
		155782	B. WIN			12/21	/2012
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
				814 S 6			
WHITE	OAK HEALTH CAMI	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		nitial tour on 12/11/12					
		CNA #18, Resident					
		ng in the lounge. The					
	resident did no	t have oxygen on.					
	During on abou	omistion on 19/19/19 of					
	_	ervation on 12/18/12 at					
	·	resident was in his					
		nis room. The resident					
	did not have o	xygen on.					
	The Physician'	s Recapitulation					
	_	12/12, indicated an					
	· ·	en at 2 liters per					
	minute continu	·					
		ous.					
	During an inter	view on 12/18/12 at					
	_	N #16 indicated the					
		d have his oxygen on.					
		70					
	During an obse	ervation on 12/18/12 at					
	12 p.m., the re	sident was sitting in the					
	lounge and did	I not have his oxygen					
	on.						
	,	105's Physician					
	•	orders, dated 12/12,					
		rder (10/28/11) for					
	, ,	ma) eye drops, one					
	drop in both ey	es daily.					
	The MAR date	ed 11/12, indicated the					
	•	ot received the eye					
		•					
		ember 3, 4, 5, 6, 7, 8, 9,					
		19, 20, 21, 22, 23, 24,					
	25, and 26, 20	12.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CO		(X3) DATE SURVEY  COMPLETED
AND PLAN	OF CURRECTION	155782	A. BUILDING	00	12/21/2012
		130702	B. WING	ADDRESS CITY STATE 7ID CODE	12/21/2012
NAME OF F	PROVIDER OR SUPPLIEF	₹	814 S 6	ADDRESS, CITY, STATE, ZIP CODE	
WHITE C	OAK HEALTH CAME	PUS		CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	COMPLETION DATE
IAG	The MAR, date resident had no drops on Dece 13, 14, 15, 16, During an inter 11:15 a.m., LP	ed 12/12, indicated the of received the eye mber 2, 3, 4, 11, 12, 17, and 18, 2012.  View on 12/18/12 at N #16 indicated the e not signed as given.	IAG	DEPLETOL 1)	DATE

State Form Event ID: KGNH11 Facility ID: 012355 If continuation sheet Page 125 of 131

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	JLTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155782	B. WIN			12/21/	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6			
WHITE							
WHILE O	AK HEALTH CAMF	-05		WONT	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0246	410 IAC 16.2-5-4	(e)(6)					
	Health Services -						
	· ,	ons may be administered					
		dication aide (QMA) only					
	•	n by a licensed nurse or					
	physician. The QI						
	appropriate autho	a PRN medication. All					
		a PRN medication. All urse or physician not on the					
		orization to administer					
	•	cumented in the nursing					
		ne time and date of the					
	contact.						
	Based on recor	rd review and	R02	46	1. Resident #105 and #107 ha	d	01/20/2013
	interview the fa	acility failed to ensure			no adverse affects noted. 2.		
		d authorization to give			Residents receiving medication	ns	
		_			from facility staff have potentia	ıl to	
		PRN) medication prior			be at risk of alleged deficient		
	,	g the medication for 2			practice. Qualified Medication		
		eviewed for PRN			Aides (QMAs) will be in-service		
	medication in a	total sample of 6.			to obtain prior authorization by	'	
	(Residents #10	5 and #107) (QMA			licensed nurse prior to		
	#15, #17, and #	<del>¥</del> 19)			administering medication.3. Nurses and QM/	۸۵	
		•			will be in-serviced on the	7.5	
	Findings includ	۵.			requirement of obtaining		
	i manigo moida	<b>C</b> .			authorization by the licensed		
	4 Decident #44	251			nurse in order for the QMA to		
		05's record was			administer PRN medications.		
		2/18/12 at 11 a.m. The			Documentation will be done to		
	resident's diagr	noses included, but			indicate authorization has bee	n	
	were not limited	d to, dementia, atrial			provided. Director of Health		
	fibrillation, and	anemia.			Services (DHS) or designee w		
	•				audit Medication Administratio		
	The Physician's	s Recapitulation			Records (MARs) 5 x's/week x		
	•	12/12, indicated an			month, 3x's/week x 1 month at weekly x 4 months to ensure	ıu	
	•				proper authorization is obtaine	d	
	order (8/14/12)				4. Audit results will be brought		
	` •	lication) 0.83% per			monthly Quality Assurance (Q		
	nebulizer every				meetings. Trends will be review		
	needed, (07/26	i/12) ipratropim BR			by QA Committee x 6 months		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	lG		12/21/	2012
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE C	OAK HEALTH CAMI	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(breathing) 0.0	2% per nebulizer four			until 100% compliance is		
	times a as nee	eded, and (5/ 25/12)			achieved.		
	anti-diarrhea 2 milligrams (mg) one tablet orally as needed with a maximum of 16 mg in a day.						
	The Medication	n Administration					
	Record (MAR)	, dated 09/12, indicated					
	QMA #15 gave	e the as needed					
	anti-diarrhea o	n 09/01/12, the					
	ipratropim on S	September 5, 26, and					
	29, 2012, and	the albuterol on					
	September 5, 2	26, and 29, 2012.					
	There was a la	ick of documentation to					
	indicate the QI	MA had obtained					
		rom a licensed nurse					
		ministration of the					
	medications.						
	The MAR. date	ed 10/12, indicated					
	· ·	inistered the as needed					
		pratropim on 10/8/12					
		uthorization of a					
	licensed nurse						
		of the medication.					
		or the medication.					
	The MAR date	ed 12/12, indicated					
	· ·	inistered the as needed					
		ecember 6 and 14.					
		anti-diarrhea on					
		2012 without prior					
		of a licensed nurse prior					
	to the administ	ration of the					
	medication.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155782	B. WIN	G		12/21/	2012
NAME OF F	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WINE OF I	KOVIDEK OK SOTTEIEF			814 S 6			
WHITE C	OAK HEALTH CAME	PUS		MONTIC	CELLO, IN 47960		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		10 <del>-</del> 1					
		107's record was					
		2/18/12 at 2 p.m. The					
	_	noses included, but					
		d to, hypertension and					
	dementia with	psychosis.					
	The Dhysisis -!	a Decemitulation					
	· ·	s Recapitulation 12/12, indicated orders					
	-	etaminophen 325 mg,					
	, ,	needed every 4-6					
		or fever, Hydrocodone					
	•	) 5/325 mg, one tablet					
		rs as needed for pain,					
	_	i (anti-anxiety) 0.5 mg					
	every 24 hours						
	_	anxiety/agitation.					
	breaktiilougii a	anxiety/agitation.					
	The MAR date	ed 11/12, indicated					
	QMA #19 adm	-					
	*	n November 26, 28,					
		and administered the					
	-	November 13 and 25,					
	•	rior authorization of a					
	licensed nurse						
		of the medication.					
		2					
	The MAR, date	ed 12/12, indicated					
	QMA #17 adm						
		n on December 7, 10,					
	and 14, 2012 v						
		of a licensed nurse prior					
	to the administ	•					
	medication.						
			- 1				I

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2013 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE	
   White O	OAK HEALTH CAMI	DIIQ	814 S 6	STH ST CELLO, IN 47960	
				T	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
	· ·			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE
PREFIX TAG	During an inter QMA #19 indic she needed to	ICY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)  Tview on 2:05 p.m., Eated she did not think have prior In an Assisted Living	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	DNSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155782	B. WING	î		12/21/	2012
NAME OF B	DOLUDED OD GUDDUTED		<u>'                                    </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			814 S 6	TH ST		
WHITE O	OAK HEALTH CAME	PUS		MONTI	CELLO, IN 47960		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R0410	410 IAC 16.2-5-12 Infection Control -	- Noncompliance					
	• •	uberculin skin test shall be					
		three (3) months prior to					
	-	n admission and read at					
		seventy-two (72) hours. e recorded in millimeters of					
		e recorded in millimeters of e date given, date read,					
		ninistered and read.					
		who have not had a					
		ative tuberculin skin test					
result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the							
		ve, a second test should					
		nin one (1) to three (3)					
		rst test. The frequency of					
	infection with tube	depend on the risk of					
		ho have a positive reaction					
		skin test shall be required					
		ray and other physical and					
		nations in order to complete					
	Based on recor	d review and	R04	10	1. Resident # 132 will have		01/20/2013
		acility failed to ensure			physician notified that annual		
		ived a yearly tuberculin			tuberculin (TB) test was misse	d in	
		test for tuberculosis)			2012. Family will also be notific		
	` ,	,			No adverse affects were noted		
		ent's reviewed for TB			Residents residing at facility ha		
		sample of 6. (Resident			potential to be at risk of alleged	d	
	#132)				deficient practice. Charts of current residents will be		
					reviewed for compliance with	ΓB	
	Findings includ	e:			tests. Any residents identified		
					out of compliance will have		
	Resident #132	record was reviewed			physician notified and orders		
	on 12/18/12 at	1:30 p.m. The			obtained and followed.3.		
		noses included, but			Licensed Nurses will be		
	_	d to, hypertension and			in-serviced on requirements fo	r	
	osteoporosis.	,, portonom ama			TB tests. Director of Health	:11	
	ostcoporosis.				Services (DHS) or designee w	III	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155782	B. WING		12/21/2012
NAME OF D	PROVIDER OR SUPPLIEF	)	STREET	ADDRESS, CITY, STATE, ZIP CODE	•
NAME OF P	ROVIDER OR SUPPLIER		814 S 6	STH ST	
	OAK HEALTH CAMI			CELLO, IN 47960	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
	The Immunizat	tion Record indicated		audit charts monthly x 6 month for compliance with TB tests.	ns
				New admissions will be audite	ed
		ceived her first step TB		upon admission for proper TB	
		1 and a second step		test implementation x 6 month	
		09/11. The record		Audit results will be brought to monthly Quality Assurance (Q	
		entation to indicate the		meetings. Trends will be revie	
		eceived a yearly TB test		by QA Committe x 6 months of	
	by in 2012.			until 100% compliance.	
	Description on the second	n dann am 40/40/40 = t			
		view on 12/18/12 at			
		Medical Records LPN			
		B test had not been			
	completed yea	rıy.			

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